

APPENDIX - REPORTS OF REFERENCE COMMITTEES
2023 Annual Meeting of the American Medical Association House of Delegates

Reference committee reports from the House of Delegates meeting are provided for the sake of convenience and because they are part of the record of each meeting.

The Proceedings reflect the official record of the actions taken by the House of Delegates and have precedence over reference committee reports, as the Proceedings are prepared using multiple sources, including a transcript of debate. Policies deriving from House actions are recorded in PolicyFinder, which is updated following each House of Delegates meeting.

Note: The original language of report recommendations and the original resolve clauses from resolutions are included in the reference committee reports with a gray background as in this example:

The Board of Trustees recommends that the following be adopted in lieu of the resolution and the remainder of this report be filed.

In addition, where the reference committee proposes changes in addition to or different from changes proposed by the original item of business, those changes are shown with double underscore or ~~double strikethrough~~, and in some cases are highlighted in yellow.

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT Report 02 - New Specialty Organizations Representation in the House of Delegates
2. BOT Report 15 - National Cancer Research Patient Identifier
3. BOT Report 21 - Specialty Society Representation in the House of Delegates - Five-Year Review
4. CEJA Report 01- Utilization Review, Medical Necessity Determination, Prior Authorization Decisions
5. CEJA Report 03 - Short-term Medical Service Trips
6. CEJA Report 04 - Responsibilities to Promote Equitable Care
7. CEJA Report 05 - CEJA's Sunset Review of 2013 House Policies
8. Resolution 005 - Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees
9. Resolution 010 - Advocating for Increased Support to Physicians in Family Planning and Fertility

RECOMMENDED FOR ADOPTION AS AMENDED

10. CCB Report 01 - AMA Bylaws and Gender Neutral Language and Miscellaneous Update
11. Resolution 002 - Exclusion of Race and Ethnicity in the First Sentence of Case Reports
12. Resolution 003 - Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation
13. Resolution 004 - Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"
14. Resolution 006 - Ensuring Privacy as Large Retail Settings Enter Healthcare
15. Resolution 007 - Independent Medical Evaluation
16. Resolution 009 - Racism - A Threat to Public Health
17. Resolution 014 – Redressing the Harms of Misusing Race in Medicine
18. Resolution 016 - Supporting Efforts to Strengthen Medical Staffs Through Collective Bargaining and/or Unionization
19. Resolution 017 - Establishing a Formal Definition of "Employed Physician"

RECOMMEND FOR ADOPTION IN LIEU OF

20. Resolution 018 - Confidentiality of Sexual Orientation and Gender Identity Data; Resolution 001 – Opposing Mandated Reporting of LGBTQ+ Status
21. Resolution 015 - Report Regarding the Criminalization of Providing Medical Care; Resolution 008 - Study on the Criminalization of the Practice of Medicine.

RECOMMENDED FOR REFERRAL

22. CEJA Report 02 - Ethical Principles for Physicians In Private Equity Owned Practices

RECOMMENDED FOR NOT ADOPTION

23. Resolution 011 - Rights of the Developing Baby
24. Resolution 012 - Viability of the Newborn
25. Resolution 013 - Serial (Repeated) Sperm Donors

The following resolutions were handled via the reaffirmation consent calendar:

- Resolution 102 – Bundling Physician Fees with Hospital Fees
- Resolution 104 – Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for HealthCare Financing
- Resolution 105 – Health Insurance that Fairly Compensates Physicians
- Resolution 106 – Hospice Recertification for Non-Cancer Diagnosis
- Resolution 107 – Medicaid Tax Benefits

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 02 - NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Recommendations in Board of Trustees Report 2 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 2 adopted and the remainder of the Report filed.

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)

Testimony was heard in general support. Your Reference Committee recommends that BOT Report 02 be adopted.

- (2) BOARD OF TRUSTEES REPORT 15 – NATIONAL CANCER RESEARCH PATIENT IDENTIFIER

RECOMMENDATION:

Recommendations in Board of Trustees Report 15 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 15 adopted and the remainder of the Report filed.

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.

Testimony was heard in support of BOT Report 15. Testimony noted that the National Cancer Institute is already developing an identification system. Your Reference Committee recommends that BOT Report 15 be adopted.

- (3) BOARD OF TRUSTEES REPORT 21 - SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR REVIEW

RECOMMENDATION:

Recommendations in Board of Trustees Report 21 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 21 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. The Aerospace Medical Association, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgeons, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Psychiatry and the Law, American Association for Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical Neurophysiology Society, American Rhinologic Society, American Society of Addiction Medicine, American Society of Echocardiography, American Society of Hematology, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society of Transplant Surgeons, Endocrine Society, International Society for Hair Restoration Surgery, North American Neuromodulation Society, North American Neuro-Ophthalmology Society, and Spine Intervention Society retain representation in the AMA HOD. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the American College of Medical Quality, American Society for Reconstructive Microsurgery, American Society of Neuroimaging, GLMA—Health Professionals Advancing LGBTQ+ Equality be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)

3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5 at the end of the one-year grace period, the American Society of General Surgeons and United States and Canadian Academy of Pathology lose representation in the AMA HOD but retain it for the AMA Specialty and Service Society (SSS) and may apply for reinstatement in the HOD, through the SSS, when they believe they can comply with all of the current guidelines for representation in the HOD, in accordance with AMA Bylaw B-8.5.3.2.2. (Directive to Take Action)

Testimony was heard in general support. Your Reference Committee recommends that BOT Report 21 be adopted.

- (4) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 01 - UTILIZATION REVIEW, MEDICAL NECESSITY DETERMINATION, PRIOR AUTHORIZATION DECISIONS

RECOMMENDATION:

**Recommendations in Council on Ethical and Judicial Affairs
Report 1 be adopted and the remainder of the Report be filed.**

**HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs
Report 1 adopted and the remainder of the Report filed.**

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.~~

(Modify HOD policy)

Testimony was heard in unanimous support, noting that prior authorization is a significant challenge for physicians, and that the recommendations are good for physicians and patients. Testimony mentioned that COL has a task force

working on this issue and it is a high priority for them. Your Reference Committee recommends that CEJA Report 01 be adopted.

- (5) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 03 – SHORT-TERM MEDICAL SERVICE TRIPS

RECOMMENDATION:

**Recommendations in Council on Ethical and Judicial Affairs
Report 3 be adopted and the remainder of the Report be filed.**

**HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs
Report 3 referred and the remainder of the Report filed**

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.

(New HOD/CEJA Policy)

Testimony was mixed. There was testimony suggesting referral, which included that the report is still written from the standpoint of the volunteers and the word "service" implies this work is unidirectional rather than collaborative. Testimony also suggested that there was insufficient discussion of partnering with local organizations and that non-financial harms to overseas partners were not discussed. It was suggested that the word "vulnerability" is not consistent with language recommended by the Center for Health Equity (CHE). However, your Reference Committee wishes to highlight that the issues of collaboration with local partners and the various types of harms service trips might cause are extensively addressed by Recommendations A and B. Further, CEJA was consulted, and points out that the word "vulnerable" does not appear in the recommendations and that the language of the report is consistent with CHE guidelines. CEJA therefore declined to amend the language. Testimony in support offered an amendment to the effect that all the recommendations should also apply to dental service trips, and they would like to see these included. However, in the judgment of the Reference Committee, such an amendment is not within the purview of the AMA and these guidelines would be more properly developed by the American Dental Association. Your Reference Committee recommends that CEJA Report 03 be adopted.

- (6) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 04 – RESPONSIBILITIES TO PROMOTE EQUITABLE CARE

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 4 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 4 adopted and the remainder of the Report filed

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.

(New HOD policy)

The majority of testimony was in support of adoption. An amendment was offered; however, CEJA reports cannot be amended without the approval of the Council. The amendment was substantive. Therefore, your Reference Committee recommends adoption of the current report recognizing that CEJA may elect to consider the issues raised in the amendment in a subsequent report. Your Reference Committee recommends that CEJA Report 04 be adopted.

- (7) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 05 – CEJA'S SUNSET REVIEW OF 2013 HOUSE POLICIES

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 5 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 5 adopted and the remainder of the Report filed

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)

No testimony was heard. Your Reference Committee recommends that CEJA Report 05 be adopted.

- (8) RESOLUTION 005 – PROVIDING CULTURALLY AND RELIGIOUSLY SENSITIVE ATTIRE OPTIONS AT HOSPITALS FOR PATIENTS AND EMPLOYEES

RECOMMENDATION:

Resolution 005 be adopted.

HOD ACTION: Resolution 005 adopted.

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)

Mixed testimony was heard. Supportive testimony emphasized the need for cultural and religious sensitivity. Limited testimony in opposition was heard to the effect that scrubs are different from hospital attire and that patient safety in the OR needs to be considered. Your Reference Committee recommends that Resolution 005 be adopted.

- (9) RESOLUTION 010 – ADVOCATING FOR INCREASED SUPPORT TO PHYSICIANS IN FAMILY PLANNING AND FERTILITY

RECOMMENDATION:

Resolution 010 be adopted.

HOD ACTION: Resolution 010 adopted.

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)

Testimony was heard in unanimous support. Supportive testimony noted that this resolution is particularly pertinent for some specialties since their residency period is longer, and thus it may encourage more women to choose those specialties. An amendment was offered by addition and deletion of a third resolve clause that would amend current AMA Policy H-185.990 "Infertility and Fertility Preservation Insurance Coverage." While your Reference Committee generally agrees with the suggested changes to Policy H-185.990, we do not find the amendment

germane to this resolution and believe that the amendment offered would be more appropriately proffered as its own resolution in the future. For this reason, your Reference Committee recommends that Resolution 010 be adopted as written.

RECOMMENDED FOR ADOPTION AS AMENDED

- (10) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 01 - AMA
BYLAWS AND GENDER NEUTRAL LANGUAGE AND
MISCELLANEOUS UPDATE

RECOMMENDATION A:

Section 3.8 Installation of Officers be amended by addition as follows:

3.8 Installation of Officers. The officers of the AMA shall assume their duties at the close of the meeting at which they are elected, except as stated herein. The medical student trustee shall assume office at the close of the Annual Meeting following the Interim Meeting at which the medical student trustee was elected. If elected at an Interim Meeting or Special Meeting, the public trustee shall assume office at the close of the Annual Meeting following ~~his or her~~ their election. If elected at an Annual Meeting, the public trustee shall assume office at the close of the Annual Meeting at which they are ~~he or she was~~ elected.

RECOMMENDATION B:

Recommendations in Council on Constitution and Bylaws Report 1 be adopted as amended remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 1 adopted as amended and remainder of the Report filed.

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.

2—House of Delegates

2.8 Alternate Delegates.

2.8.6 Status. The alternate delegate is not a “member of the House of Delegates” as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates, nor vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates. The alternate delegate must immediately relinquish ~~his or her~~ their position on the floor of the House of Delegates upon the request of the delegate for whom the alternate delegate is substituting.

3—Officers

3.4 Elections.

3.4.2.1.1 First Ballot. All nominees for the office of At-Large Trustee shall be listed alphabetically on a single ballot. Each elector shall have as many votes as the number of Trustees to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more votes than the number of Trustees to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if they he or she has have received a vote on a majority of the legal ballots cast and is are one of the nominees receiving the largest number of votes within the number of Trustees to be elected.

3.5 Terms and Tenure.

3.5.7.1 Limitations. No candidate shall be eligible for election or re-election as the young physician trustee unless, at the time of election, he or she is they are under 40 years of age or within the first eight years of practice after residency and fellowship training, and is are not a resident/fellow physician. A young physician trustee shall be eligible to serve on the Board of Trustees for the full term for which elected, even if during that term the trustee reaches 40 years of age or completes the eighth year of practice after residency and fellowship training.

3.8 Installation of Officers. The officers of the AMA shall assume their duties at the close of the meeting at which they are elected, except as stated herein. The medical student trustee shall assume office at the close of the Annual Meeting following the Interim Meeting at which the medical student trustee was elected. If elected at an Interim Meeting or Special Meeting, the public trustee shall assume office at the close of the Annual Meeting following ~~his or her~~ their election. If elected at an Annual Meeting, the public trustee shall assume office at the close of the Annual Meeting at which ~~he or she was~~ elected.

6—Councils

6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.8.1.2 Other Council Members. With reference to each such Council, all nominees for election shall be listed alphabetically on a single ballot. Each elector shall have as many votes as there are members to be elected, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer votes or more votes than the number of members to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if ~~he or she~~ they have has received a vote on a majority of the legal ballots cast and is are one of the nominees receiving the largest number of votes within the number of members to be elected.

7—Sections

7.4 Organized Medical Staff Section.

7.4.1 Membership. Membership in the Section shall be open to all active physician members of the AMA who are members of a medical staff of a hospital or a medical staff of a group of practicing physicians organized to provide healthcare. Active resident and fellow members of the AMA who are ~~selected~~ certified by their medical staffs as representatives to the Business Meeting also shall be considered members of the Section.

7.4.2 Representatives to the Business Meeting. Each medical staff of a hospital and each medical staff of a group of practicing physicians organized to provide healthcare may select up to two active physician AMA member representatives to the Business Meeting. The president or chief of staff of a medical staff may also attend the Business Meeting as a representative if ~~he or she is~~ they are an active physician member of the AMA. The representatives must be physician members of the medical staff of a hospital or group of practicing physicians organized to provide healthcare or residents/fellows affiliated with the medical staff of a hospital or group of practicing physicians organized to provide healthcare. All representatives to the Business Meeting shall be properly certified in accordance with procedures established by the Governing Council and approved by the Board of Trustees.

7.4.2.1 When a multi-hospital system and its component 1 medical staffs have unified the medical staffs, those medical staff members who hold specific privileges to practice at each separate entity within the unified system may select up to two representatives to the Business Meeting, so long as they are active physician members of the AMA. The president or chief of staff of a unified medical staff also may attend the Business Meeting as a representative if ~~he or she is~~ they are an active physician member of the AMA.

7.7 Minority Affairs Section.

7.7.3.1 Section Representatives on the Governing Council. If a representative of the Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which ~~he or she~~ they ceases to meet the membership requirement of the respective section.

7.7.3.2 Section Representative as Immediate Past Chair. A Section representative who has been elected as chair of the Governing Council, but who ceases to meet the criteria for membership in the section from which elected during ~~his or her~~ their term as Immediate Past Chair, shall be permitted to complete the term of office, as long as the officer remains an active physician member of the AMA.

7.10 Women Physicians Section.

7.10.3.1 Section Representatives on the Governing Council. If a representative of the Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which ~~she or he~~ they ceases to meet the membership requirement of the respective section.

(Modify Bylaws)

Testimony was heard in unanimous support. It was noted that this change follows similar changes in many other major organizations, promotes respect for the dignity of all people, communicates belonging, and challenges marginalization. A minor amendment was offered to make the language consistent throughout. Your Reference Committee recommends that CCB Report 01 be adopted as amended.

- (11) RESOLUTION 002 – EXCLUSION OF RACE AND ETHNICITY IN THE FIRST SENTENCE OF CASE REPORTS

RECOMMENDATION A:

That the first resolve of Resolution 002 be amended by addition as follows:

RESOLVED, That our American Medical Association encourage curriculum and clinical practice that omits race, preferred spoken language, and/or ethnicity from the first sentence of case reports and other medical documentation (New HOD Policy); and be it further

RECOMMENDATION B:

That the second resolve of Resolution 002 be amended by addition as follows:

RESOLVED, That our AMA encourage the maintenance of race, preferred spoken language, and ethnicity in other relevant sections of case reports and other medical documentation. (New HOD Policy)

RECOMMENDATION C:

Resolution 002 be adopted as amended.

RECOMMENDATION D:

That the title of Resolution 002 be amended by addition as follows:

RESOLUTION 002 – EXCLUSION OF RACE, PREFERRED SPOKEN LANGUAGE, AND ETHNICITY IN THE FIRST SENTENCE OF CASE REPORTS

HOD ACTION: Resolution 002 adopted as amended with a change in title:

RESOLUTION 002 – EXCLUSION OF RACE, PREFERRED SPOKEN LANGUAGE, 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)

Testimony was mixed. An amendment was offered on the basis that “preferred spoken language” should not be included in the first sentence of case reports since it also can introduce bias into the treatment of patients. Opposing

testimony noted that in order to have interpreters available, physicians must be able to easily determine which language is spoken by the patient. Your Reference Committee noted that the second resolve specifies that these descriptors should still be included in other relevant sections of case reports, and not eliminated altogether. Online testimony was unanimously in strong support and stated that removing race from the first sentence of case reports is an important additional step to eliminating racism in medicine. Your Reference Committee would like to emphasize that factors such as race, preferred spoken language and other cultural and social needs are critical for quality patient care and should be included elsewhere in the patient's documentation. Your Reference committee recommends that Resolution 002 be adopted as amended, with a change in title.

- (12) RESOLUTION 003 – LAYING THE FIRST STEPS TOWARDS A TRANSITION TO A FINANCIAL AND CITIZENSHIP NEED BLIND MODEL FOR ORGAN PROCUREMENT AND TRANSPLANTATION

RECOMMENDATION A:

That the first resolve of Resolution 003 be amended by addition as follows:

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, who can follow transplant-center specific protocols such that they can receive transplants and obtain required medical care and medications after transplantation, including financial coverage for appropriate living donors, excluding medical tourism as defined in the AMA Code of Ethics 1.2.13 (New HOD Policy); and be it further

RECOMMENDATION B:

That the third resolve, subsection (1)(c), of Resolution 003 be amended by deletion as follows:

(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.

RECOMMENDATION C:

That the third resolve, subsection (7), of Resolution 003 be amended by addition as follows:

(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all ethically available means.

RECOMMENDATION D:

Resolution 003 be adopted as amended.

HOD ACTION: Resolution 003 adopted as amended

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)

Testimony unanimously supported Resolution 003. An amendment was offered emphasizing that all patients must be able to adhere to transplant protocols in order to be considered for a transplant. The authors of the resolution supported the amendment.

In addition, your Reference Committee offers an amendment to add the word "ethically" to subsection (7). Your Reference Committee recommends that Resolution 003 be adopted as amended.

- (13) RESOLUTION 004 – AMENDING POLICY H-525.988, “SEX AND GENDER DIFFERENCES IN MEDICAL RESEARCH”

RECOMMENDATION A:

That subsection (7) of the third resolve of Resolution 004 be referred.

RECOMMENDATION B:

That the remainder of Resolution 004 be adopted as amended.

HOD ACTION: Resolution 004 adopted as amended

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)

Testimony was mixed; however, the majority was in support. Online testimony was unanimously in strong support with several delegations citing the lack of inclusion of sexual and gender minorities in clinical research which can affect outcomes and the ability of researchers to properly analyze clinical trial data. Online testimony also noted the need for greater inclusion of sexual and gender minority participants in all aspects of clinical research and the clinical review process to minimize implicit bias and underreporting of adverse effects.

Opposing testimony asked that subsection 7 be referred. Your Reference Committee believes this is appropriate since it concerns internal FDA procedures, and it is not within the AMA’s purview to encourage or advocate for procedures to be implemented exclusively within other organizations. Your Reference Committee recommends that subsection 7 be referred, and that the remainder of Resolution 004 be adopted.

- (14) RESOLUTION 006 – ENSURING PRIVACY AS LARGE RETAIL SETTINGS ENTER HEALTHCARE

RECOMMENDATION A:

That Resolution 006 be amended by addition and deletion as follows:

RESOLVED, That our American Medical Association study privacy protections, privacy consent practices, ~~and~~ the potential for data breaches,

and the use of health data for non-clinical purposes of healthcare records in large retail healthcare settings. (Directive to Take Action)

RECOMMENDATION B:

Resolution 006 be adopted as amended.

RECOMMENDATION C:

RESOLVED, that the title be amended by addition and deletion as follows:

**ENSURING PRIVACY AS ~~LARGE~~ IN RETAIL HEALTHCARE
SETTINGS ~~ENTER HEALTHCARE~~**

HOD ACTION: Resolution 006 adopted as amended with a change in title:

**ENSURING PRIVACY AS ~~LARGE~~ IN RETAIL HEALTHCARE
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)

Testimony was heard in unanimous support, noting that Resolution 006 represents a strong commitment to patient privacy. An amendment was offered regarding use of health data for nonclinical purposes, and your Reference committee agreed with this addition. Your Reference Committee eliminated “large” from the language of the resolution because it should apply to all retail settings, regardless of size. Your Reference Committee recommends that Resolution 006 be adopted as amended, with a title change to reflect these changes.

(15) RESOLUTION 007 – INDEPENDENT MEDICAL EVALUATION

RECOMMENDATION A:

That resolution 007 be amended by addition and deletion as follows:

RESOLVED, That our American Medical Association study and report back at the 2024 Annual Meeting on the Independent Medical Evaluation (IME) processes and recommend standards and safeguards to protect ~~injured and disabled~~ patients. (Directive to Take Action)

RECOMMENDATION B:

Resolution 007 be adopted as amended.

HOD ACTION: Resolution 007 referred for decision.

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)

Testimony was heard in general support. Testimony in favor of Resolution 007 noted that IMEs are critically important, though IMEs have various meanings and definitions in a variety of contexts. Examples were provided, such as court-ordered or psychiatric evaluations. An amendment was offered that suggested this study should include consultation with a wide variety of experts within the field of IMEs, in particular those familiar with the AMA’s standards. Limited opposition was heard, noting that different fields have different terms, and that

Resolution 007 does not capture the complexity of the issue. Your Reference Committee agrees with the rationale and language of the proffered amendment and believes that it addresses the primary concerns raised in opposition. Therefore, your Reference Committee recommends that Resolution 007 be adopted as amended.

(16) RESOLUTION 009 – RACISM - A THREAT TO PUBLIC HEALTH

RECOMMENDATION A:

That resolution 009 be amended by addition and deletion as follows:

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 (including systemic racism and unconscious bias), a code that will provide physicians with a the tools necessary to address document the clinical impact of racism within the clinical encounter, and capture the data needed to help provide more effective patient care.

Resolution 009 be adopted as amended.

HOD ACTION: Resolution 009 adopted as amended.

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)

Testimony was heard in general support. An amendment was offered to clarify the language. Opposing testimony noted that there already exists an ICD code that addresses racism and that adding a new ICD code could lead to underreporting, which might negatively impact data quality. Testimony in favor responded by claiming that the new ICD code proposed by the resolution is different from existing ICD codes, since it focuses on the patient's unique experience. While creating a new code may not be a perfect means to capture data on racism, it will open up an important conversation about the issue, and that any concerns of underreporting are superseded by the current inability to capture significant patient experiences. Your Reference Committee agrees with the rationale and language of the proffered amendment and recommends that Resolution 009 be adopted as amended.

(17) RESOLUTION 014 – REDRESSING THE HARMS OF MISUSING RACE IN MEDICINE

RECOMMENDATION A:

That the third resolve of Resolution 014 be amended by addition and deletion as follows;

RESOLVED, That our AMA advocate for 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.

RECOMMENDATION B:

That Resolution 014 be adopted as amended.

HOD ACTION: Resolution 014 adopted as amended.

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)

Testimony was heard in unanimous support of this resolution. In the online testimony, a minor amendment was proffered to the third resolve. Your Reference Committee recommends that Resolution 014 be adopted as amended.

- (18) RESOLUTION 016 - SUPPORTING EFFORTS TO STRENGTHEN MEDICAL STAFFS THROUGH COLLECTIVE BARGAINING AND/OR UNIONIZATION

RECOMMENDATION A:

That the first resolve of Resolution 016 be amended by addition and deletion as follows:

RESOLVED, That our American Medical Association reevaluate the various efforts to achieve collective actions bargaining and/or unionization for physicians nationally (Directive to Take Action); and be it further

RECOMMENDATION B:

That that the second resolve of Resolution 016 be deleted.

~~**RESOLVED, that our American Medical Association develop a specific program of assistance, including education in the process of collective actions and potentially financial assistance, to be available through a process of application, review, and approval for organizers of such collective action (Directive to Take Action); and be it further**~~

RECOMMENDATION C:

That Resolution 016 be adopted as amended.

Recommendation D:

That the title for Resolution 016 be amended by addition and deletion as follows:

**SUPPORTING EFFORTS TO STRENGTHEN MEDICAL STAFFS
THROUGH COLLECTIVE ACTIONS BARGAINING AND/OR
UNIONIZATION**

HOD ACTION: Resolution 016 adopted as amended with a change in title:

**SUPPORTING EFFORTS TO STRENGTHEN MEDICAL STAFFS
THROUGH COLLECTIVE ACTIONS BARGAINING AND/OR
UNIONIZATION**

RESOLVED, That our American Medical Association reevaluate the various efforts to achieve collective bargaining and/or unionization for physicians nationally (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association develop a specific program of assistance, including education in the process of collective actions and potentially financial assistance, to be available through a process of application, review, and approval for organizers of such collective action (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association request CEJA to review the advisory restricting collective action in section 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform (Directive to Take Action).

Testimony was heard in general support. Testimony noted that the current landscape has changed since the last time the AMA reviewed collective action. Current CEJA wording on collective action was said to be too restrictive, and testimony was raised that collective action should not be equated with strikes, as there are other forms that collective action may take. Testimony also noted that burnout and other pressing physician challenges might be addressed through collective actions. An amendment was offered to change language from “collective bargaining” to “collective action” within Resolution 016 as it is wider in scope. Your Reference Committee agrees with the rationale and language of this proffered amendment. In addition, your Reference Committee recommends amendment by striking the second resolve, since it is not possible to develop a program of assistance until the AMA has reevaluated recent efforts to achieve collective action and CEJA has reviewed existing guidance in Opinion 1.2.10 of the Code of Medical Ethics. Your Reference Committee recommends that Resolution 016 be adopted as amended, with a title change.

- (19) RESOLUTION 017 - ESTABLISHING A FORMAL DEFINITION OF
“EMPLOYED PHYSICIAN”

RECOMMENDATION A:

That resolution 017 be amended by deletion as follows:

RESOLVED, That our American Medical Association adopt the following as its definition of “employed physician”:

An employed physician is any physician, ~~not in training~~, who derives compensation, financial or otherwise, from a contractual relationship with a practice, hospital, or other funding entity and has no direct controlling interest in the entity” (New HOD Policy).

HOD ACTION: Resolution 017 amended by deletion.

RESOLVED, That our American Medical Association adopt the following as its definition of “employed physician”:

An employed physician is any physician, not in training, who derives compensation, financial or otherwise, from a contractual relationship with a practice, hospital, or other funding entity and has no direct controlling interest in the entity” (New HOD Policy).

Testimony was heard in overwhelming support of the concept. Further testimony wished to strike “not in training” from the resolution, since this language would exclude residents and fellows. In light of the US Supreme Court’s 2011 unanimous decision in *Mayo Foundation v. United States*, which found that medical residents qualify as employees since they pay payroll taxes, your Reference Committee agrees with the rationale and language of the proffered amendment and recommends that Resolution 017 be adopted as amended.

RECOMMEND FOR ADOPTION IN LIEU OF

(20) RESOLUTION 001 – OPPOSING MANDATED REPORTING OF LGBTQ+ STATUS

RESOLUTION 018 - Confidentiality of Sexual Orientation and Gender Identity Data

RECOMMENDATION A:

That Resolution 018 be adopted in lieu of Resolution 001.

RESOLVED, That AMA Policy H-65.959, “Opposing Mandated Reporting of People Who Question Their Gender Identity” be amended by addition and deletion to read as follows:

Our AMA opposes mandated reporting or disclosure of patient information related to sexual orientation, of individuals who question or express interest in exploring their gender identity, gender dysphoria, intersex identity, and any information related to gender transition for all individuals, including minors.

HOD ACTION: Resolution 018 adopted in lieu of Resolution 001.

Resolution 001

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)

Resolution 018

RESOLVED, That AMA Policy H-65.959, “Opposing Mandated Reporting of People Who Question Their Gender Identity” be amended by addition and deletion to read as follows:

Opposing Mandated Reporting of People Who Question Their Gender Identity, H-65.959

Our AMA opposes mandated reporting or disclosure of patient information related to sexual orientation, of individuals who question or express interest in exploring their gender identity, gender dysphoria, intersex identity, and any information related to gender transition for all individuals, including minors.

Supportive testimony was offered by several delegations regarding the harmful consequences, including physical safety risks, increased stress, mental health degradation and discrimination. Concerns were raised that mandating the reporting of LGBTQ+ status could deter individuals from seeking necessary healthcare. Your Reference Committee believes that Resolution 018 better captures the intent of both resolutions; therefore, your Reference Committee recommends that Resolution 018 be adopted in lieu of Resolution 001.

(21) RESOLUTION 008 – STUDY ON THE CRIMINALIZATION OF THE PRACTICE OF MEDICINE

RESOLUTION 015 - REPORT REGARDING THE CRIMINALIZATION OF PROVIDING MEDICAL CARE

RECOMMENDATION A:

That Resolution 015 be amended by addition and deletion as follows:

RESOLVED, That our American Medical Association study the changing environment in which some medical ~~the practices of medicine has~~ have been criminalized including; ~~and~~ the degree to which such ~~as~~ 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 assessment, and the degree to which hospitals and health care systems are responding to this rapidly changing environment, with report reporting back to the HOD no later than the June, 2024 Annual Meeting November 2023 Interim meeting.

RECOMMENDATION B:

That Resolution 015 be adopted as amended in lieu of Resolution 008.

HOD ACTION: Resolution 015 adopted as amended in lieu of Resolution 008.

Resolution 008

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)

Resolution 015

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)

Testimony on both resolutions was supportive. Overwhelming support noted that the criminalization of the practice of medicine has created an environment of increased anxiety and fear that is unacceptable. An amendment was offered to move up the timeframe of the study so that findings could be reported back no later than I-23.

An additional amendment was suggested as follows: “the AMA strongly support any physician charged with a crime arising from their providing care which is in accordance with specialty society guidelines.” Your Reference Committee acknowledges this second amendment and suggests that the feasibility of such support should be included in the study outlined. Online testimony noted that the threat of criminalization has significant implications for both physicians and patients, and an amendment was offered to include how hospitals and health care systems are responding to this rapidly changing environment due to the importance of assessing how hospitals are moving to protect themselves, as there is a risk of physicians and other healthcare professionals becoming scapegoats. Due to the identical nature of Resolution 008 and Resolution 015, your Reference Committee recommends adoption of Resolution 015 in lieu of Resolution 008.

RECOMMENDED FOR REFERRAL

- (22) COUNCIL ON ETHICAL AND JUDICIAL AFFIARS REPORT 02 - ETHICAL PRINCIPLES FOR PHYSICIANS IN PRIVATE EQUITY OWNED PRACTICES

RECOMMENDATION:

**Recommendations in Council on Ethical and Judicial Affairs
Report 2 be referred back to CEJA.**

**HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs
Report 2 referred back to CEJA.**

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.

(Modify HOD policy)

Testimony was predominantly in opposition. Testimony noted that the report does not address the ethical implication of profit expectations, especially if it comes at the cost of supporting physicians and patients. In general, testimony noted that the recommendations are not strong enough and lack sufficient detail. In particular, it was suggested that more clarity is needed on the definition and scope of the term "financial obligation." Your Reference Committee recommends that CEJA Report 02 be referred back to CEJA with a request for a report back at I-23.

RECOMMENDED FOR NOT ADOPTION

(23) RESOLUTION 011 – RIGHTS OF THE DEVELOPING BABY

RECOMMENDATION:

Resolution 011 be not adopted.

HOD ACTION: Resolution 011 not adopted.

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)

Overwhelming opposing testimony was heard. Several members stated that the AMA has recently reaffirmed its current policy on reproductive rights, which is in contradiction with Resolution 011. Online testimony in opposition also notes that this issue has been discussed by CEJA in *Code Opinions* 4.1.2 Genetic Testing for Reproductive Decision Making, 7.3.4 Maternal-Fetal Research, 2.2.3 Mandatory Parental Consent to Abortion, and 4.2.7 Abortion. Your Reference Committee recommends that Resolution 011 be not adopted.

(24) RESOLUTION 012 – VIABILITY OF THE NEWBORN

RECOMMENDATION:**Resolution 012 be not adopted.****HOD ACTION: Resolution 012 not adopted**

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)

Testimony in opposition highlighted that existing CEJA policy already addresses the issues raised by Resolution 012, specifically citing the AMA *Code of Ethics* “Opinion 2.2.14 - Treatment Decisions for Seriously Ill Newborns,” in which CEJA offers guidance on children born at the edge of viability. Your Reference Committee recommends that Resolution 012 be not adopted.

(25) RESOLUTION 013 – SERIAL (REPEATED) SPERM DONORS

RECOMMENDATION:**Resolution 013 be not adopted.****HOD ACTION: Resolution 013 not adopted.**

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)

Testimony was heard in general opposition. It was noted that ASRM already has policy on this issue and is conducting research to study the issue further. Your Reference Committee believes that this resolution is outside of the purview of the AMA and instead falls within the scope of specialist societies. Your Reference Committee recommends that Resolution 013 be not adopted.

REPORT OF REFERENCE COMMITTEE A

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 02 – Medicare Coverage of Dental, Vision, and Hearing Services
2. Council on Medical Service Report 03 – Private Insurer Payment Integrity
3. Council on Medical Service Report 04 – Bundled Payments and Medically Necessary Care
4. Council on Medical Service Report 07 – Reporting Multiple Services Performed During a Single Patient Encounter
5. Resolution 117 – Payment for Physicians Who Practice Street Medicine

RECOMMENDED FOR ADOPTION AS AMENDED

6. Resolution 101 – Updating Physician Job Description for Disability Insurance
7. Resolution 105 – Studying Population-Based Payment Policy Disparities
8. Resolution 107 – Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use
9. Resolution 109 – Improved Access to Care for Patients in Custody of Protective Services
10. Resolution 110 – Long-Term Care Coverage for Dementia Patients
11. Resolution 116 – Medicare Coverage of OTC Nicotine Replacement Therapy
12. Resolution 118 – Advancing Acute Care at Home
13. Resolution 120 – Supporting Permanent Reimbursement of Acute Hospital Care at Home
13. Resolution 119 – Rescinding the Medicare Three-Day Hospital Inpatient Requirement for Nursing Home Admission

RECOMMENDED FOR ADOPTION IN LIEU OF

14. Resolution 104 – Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment
15. Resolution 112 – Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs

RECOMMENDED FOR REFERRAL

16. Resolution 103 – Movement Away from Employer-Sponsored Health Insurance
17. Resolution 106 – Billing for Traditional Healing Services
18. Resolution 108 – Sustainable Reimbursement for Community Practices

RECOMMENDED FOR NOT ADOPTION

19. Resolution 102 – Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

20. Resolution 113 – Cost of Insulin

RECOMMENDED FOR ADOPTION

- (1) COUNCIL ON MEDICAL SERVICE REPORT 02 -- MEDICARE COVERAGE OF DENTAL, VISION, AND HEARING SERVICES

RECOMMENDATION:

Recommendations in Council on Medical Service Report 02 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 02 adopted and the remainder of the report filed.

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the referred Resolve clause of Alternate Resolution 113-A-22, and the remainder of the report be filed:

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)

Testimony was generally supportive of Council on Medical Service Report 02. A member of the Council on Medical Service acknowledged that coverage for dental, vision, and hearing services is important to patients while also emphasizing that an expansion of Medicare to cover these services is not a viable option at this time. The Council member cited the current rate of inflation, the high costs projected to cover these services, and statutory budget

neutrality requirements in explaining why the AMA must continue to be sensitive to the implications of adding such services to Medicare.

One commenter proffered amendments to the recommendations of the report to: 1) support new Medicare appropriations to cover periodic vision exams, prescription eyeglasses, hearing aids, and aural rehabilitation services; and 2) support federal and state financial assistance for senior patients to purchase dental care. Another amendment asked that the AMA support dental coverage under Medicare as long as physician reimbursements are increased to sustainable practice levels. A member of the Council on Medical Service stated that the Council discussed the option of supporting new Medicare appropriations for dental, vision, and hearing coverage but concluded the current climate would be unfavorable to the proposed coverage expansions. The Council member further stated that the coverage expansions are not currently feasible. Your Reference Committee concurs and recommends that the recommendations in Council on Medical Service Report 02 be adopted as written.

- (2) COUNCIL ON MEDICAL SERVICE REPORT 03 -- PRIVATE INSURER
PAYMENT INTEGRITY

RECOMMENDATION:

Recommendations in Council on Medical Service Report 03 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 03 adopted and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 110-A-22, and the remainder of the report be filed:

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:

4. 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)

In addition to testimony that was supportive of CMS Report 03 as written, amendments were proffered to the recommendations of the report to: 1) expand Recommendation 1 to include all medical necessity determinations in order to account for off-label drug use or infrequently performed procedures; 2) replace the term “government payers” in Recommendation 3 to a more identifiable benchmark, such as “Medicare;” and 3) ensure that infrequently performed procedures are not automatically deemed experimental/investigational.

The Council on Medical Service commented that the amendments go beyond the purview of this report, as expanding the reach of medical necessity determinations to include off-label drug use or infrequently performed procedures may be premature given that a comprehensive, evidence-based process to establish consistency in those determinations has not yet been developed. The Council on Medical Service also noted that the term “government payers” was used purposefully in Recommendation 3 to avoid limiting the benchmark to a single public payer. Your Reference Committee agrees. Therefore, your Reference Committee recommends that the recommendations be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 04 -- BUNDLED PAYMENTS AND MEDICALLY NECESSARY CARE

RECOMMENDATION:

Recommendations in Council on Medical Service Report 04 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 04 adopted and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 111-A-22, and that the remainder of the report be filed:

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)

Testimony was unanimously supportive of Council on Medical Service Report 04 and its approach to safeguarding medically necessary care under bundled payment models. A member of the Council on Medical Service stated that the concerns raised in the referred resolution were addressed through recommended amendments to AMA policy intended to protect access to medically necessary care under these models and ensure that functional improvements are measured when appropriate, as for orthopedic bundles. The authors of the referred resolution also testified in strong support of the report. Accordingly, your Reference Committee recommends adoption of the recommendations in Council on Medical Service Report 04.

- (4) COUNCIL ON MEDICAL SERVICE REPORT 07 -- REPORTING
MULTIPLE SERVICES DURING A SINGLE PATIENT ENCOUNTER

RECOMMENDATION:

Recommendations in Council on Medical Service Report 07 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 07 adopted and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 824-I-22, and the remainder of the report be filed:

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)

Testimony was overwhelmingly supportive of CMS Report 07. A member of the Council on Medical Service introduced the report, noting that it addresses the fact that while *Current Procedural Terminology* (CPT®) offers a valid way to report multiple services, there is a disconnect between physicians and payers regarding the feasibility of

providing, documenting, reporting, and paying for multiple services. Your Reference Committee recommends the recommendations be adopted and the remainder of the report be filed.

- (5) RESOLUTION 117 -- PAYMENT FOR PHYSICIANS WHO PRACTICE STREET MEDICINE

RECOMMENDATION:

Resolution 117 be adopted.

HOD ACTION: Resolution 117 adopted.

RESOLVED, That our American Medical Association support the development of street medicine programs to increase access to care for populations experiencing homelessness and reduce long-term costs (New HOD Policy); and be it further

RESOLVED, That our AMA support the implementation of Medicare and Medicaid payment for street medicine initiatives by advocating for necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers for Medicaid & Medicaid Services asking that it establish a new place-of-service code to support street medicine practices for people eligible for Medicare and/or Medicaid, with “street medicine” defined, in keeping with the Street Medicine Institute, as “the provision of health care directly to people where they are living and sleeping on the streets.” (Directive to Take Action)

Your Reference Committee heard strong support for Resolution 117, with multiple commenters reiterating that development of a new Place of Service (POS) code is essential to fulfilling the ask of the resolution. Lack of an appropriate POS code results in delay of payment and denial of payment – and that a new POS code is necessary for better epidemiological tracking. Additionally, it was noted that women and families are the fastest growing segment of the unhoused, with 20% of them becoming unhoused due to domestic violence. The current infrastructure limits physicians’ ability to provide care and their ability to bill for care would increase access considerably. The Council on Medical Service agreed that increasing access to care for underserved populations will contribute to eradicating homelessness. Accordingly, your Reference Committee recommends that Resolution 117 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (6) RESOLUTION 101 -- UPDATING PHYSICIAN JOB DESCRIPTION FOR DISABILITY INSURANCE

RECOMMENDATION A:

Resolution 101 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support efforts 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)

RECOMMENDATION B:

Resolution 101 be amended by addition of a new Resolved to read as follows:

RESOLVED, That our American Medical Association support removing the barriers to obtaining and claiming disability insurance for physicians on visas. (Directive to Take Action)

RECOMMENDATION C:

Resolution 101 be adopted as amended.

HOD ACTION: Resolution 101 adopted as amended.

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)

Your Reference Committee heard mostly supportive testimony for Resolution 101. Commenters noted physicians must be able to perform the duties required of their specific specialty in order to claim disability insurance and the current classification is based on outdated definitions, which places physicians at a significant disadvantage. Testimony supported amending the resolution rather than calling for a study and adding a second resolved clause to support physicians on H-1 and J-1 visas who are typically not eligible for disability insurance.

Testimony from the Council on Medical Service agreed that while it is important that physician job descriptions accurately reflect the current physical, cognitive, and emotional demands of the position, the AMA does not possess the expertise to develop specialty-specific physician job descriptions. Therefore, the Council recommended amending the resolution to allow the AMA to support these efforts. Your Reference Committee agrees with this amendment and testimony that a second resolved clause on supporting International Medical Graduates is warranted. Accordingly, your Reference Committee recommends that Resolution 101 be adopted as amended.

(7) **RESOLUTION 105 -- STUDYING POPULATION-BASED PAYMENT POLICY DISPARITIES**

RECOMMENDATION A:

Resolution 105 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support 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 New HOD Policy); and be it further

RESOLVED, That our AMA support the ongoing effort of members of the federation to analyze the study the effects of factors such as valuation of CPT codes describing similar services by gender to ensure equitable valuation, toward equitable 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);and be it further

RESOLVED, That our AMA reaffirm Policy H-385.921 Health Care Access for Medicaid Patients and H-290.976 Enhanced SCHIP Enrollment, Outreach, and Reimbursement. (Reaffirm HOD Policy)

RECOMMENDATION B:**Resolution 105 be adopted as amended.****HOD ACTION: Resolution 105 adopted as amended.**

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)

Your Reference Committee heard supportive testimony on Resolution 105. The Chair of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) spoke in favor of the spirit of the resolution, recognizing that the second resolved clause has been addressed via its Relativity Assessment Workgroup, which incorporated gender equity via the CPT coding and valuation process, working in collaboration with the American Urological Association and the American College of Obstetricians and Gynecologists.

The Council on Medical Service testified that the AMA has developed principles and actions to address the physician work force, as well as policy on supporting efforts to quantify the physician shortage in many specialties. The Council also noted that the AMA has key policies on the adequacy of Medicaid reimbursement which could be considered the underlying issue of this resolution. These key policies affirm the AMA commitment to advocating for reasonable Medicaid reimbursement for its medical providers, defined as at minimum 100% of RBRVS Medicare allowable. A third resolve clause was recommended to reaffirm H-385.921 Health Care Access for Medicaid Patients and H-290.976 Enhanced SCHIP Enrollment, Outreach, and Reimbursement.

The author of the resolution rose in support of the amended language. Therefore, your Reference Committee recommends that Resolution 105 be adopted as amended. An amendment was proffered that related to the Veterans Administration and the Indian Health Services fee schedules, but we believe that to be out of the scope of this resolution.

Health Care Access for Medicaid Patients H-385.921

It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100% of the RBRVS Medicare allowable.

(Res. 103, A-07; Reaffirmed: CMS Rep. 2 I-08; Reaffirmation A-12; Reaffirmed: Res 132, A-14; Reaffirmed in lieu of Res. 808, I-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 807, I-18)

Enhanced SCHIP Enrollment, Outreach, and Reimbursement H-290.976

1. It is the policy of our AMA that prior to or concomitant with states' expansion of State Children's Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.

2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100% of RBRVS Medicare allowable.

(Res. 103, I-01; Reaffirmation A-07; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, I-14; Reaffirmation A-15; Reaffirmed: CMS Rep. 3, A-15; Reaffirmation: A-17; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: CMS Rep. 1, I-22)

- (8) RESOLUTION 107 -- REDUCING THE COST OF CENTERS FOR MEDICARE AND MEDICAID SERVICES LIMITED DATA SETS FOR ACADEMIC USE

RECOMMENDATION A:

Resolution 107 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~encourage the Centers for Medicare and Medicaid Services to adjust the~~ support reduced pricing of limited data sets in order to increase access for academic, nonprofit, and government researchers use. (New HOD Policy)

RECOMMENDATION B:

Resolution 107 be adopted as amended.

RECOMMENDATION C:

Title of Resolution 107 be changed to read as follows:

REDUCING THE COST OF LIMITED DATA SETS

HOD ACTION: Resolution 107 adopted as amended with new Resolve and change in title.

RESOLVED, That our AMA advocate that Centers for Medicare and Medicaid Services fully comply with Section 105(b) of the Medicare and CHIP Reauthorization Act of 2015 (MACRA), in order to grant Qualified Clinical Data Registries (QCDRs) timely and cost-effective access to Medicare claims data for research to support quality improvement and patient safety, and further advocate for additional federal funding if necessary to implement this statutory requirement. (Directive to Take Action)

REDUCING THE COST OF LIMITED DATA SETS

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)

Testimony was generally supportive of Resolution 107. Some speakers suggested amending the resolution to expand the types of organizations and researchers who could benefit from reduced pricing of data sets. Additionally, a member of the Council on Medical Service noted that Centers for Medicare and Medicaid Services (CMS) data sets can be cheaper than non-governmental data sets and suggested amending the Resolved clause so that it is not limited to CMS limited data sets. Your Reference Committee believes the amended Resolved clause is sufficiently broad to allow the AMA to take the action proposed in proffered alternate language, which asked the AMA to advocate that CMS comply with Section 105(b) of the Medicare and CHIP Reauthorization Act of 2015 (MACRA) on expanding access to Medicare data by qualified clinical data registries for quality improvement. Accordingly, your Reference Committee recommends that Resolution 107 be adopted as amended and that the title be changed to reflect the amended Resolved clause.

- (9) RESOLUTION 109 -- IMPROVED ACCESS TO CARE FOR PATIENTS IN CUSTODY OF PROTECTIVE SERVICES

RECOMMENDATION A:

Resolution 109 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~study and report back~~ support mechanisms to improve payment for physician services provided to patients under protective services custody. (Directive to Take Action)

RECOMMENDATION B:

Resolution 109 be adopted as amended.

HOD ACTION: Resolution 109 adopted as amended.

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)

Your Reference Committee heard testimony in favor of Resolution 109 that emphasized the importance of valuing the additional work involved in providing care to the vulnerable patient population under protective services custody. Testimony clarified that anyone can bring a coding proposal to the CPT Editorial Panel. It was also acknowledged that each state may approach this differently as they have their own local codes used by Medicaid plans. The Council on Medical Service was supportive and recognized that a study is not necessary as the AMA has substantial policy on ensuring adequate Medicaid payment rates and recognizing the additional resources required to appropriately care for patients taking into account their social determinants of health. Therefore, your Reference Committee recommends that Resolution 109 be adopted as amended.

- (10) RESOLUTION 110 -- LONG-TERM CARE COVERAGE FOR DEMENTIA PATIENTS

RECOMMENDATION A:

Resolution 110 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with Centers for Medicare & Medicaid Services and other relevant stakeholders to formulate appropriate medical insurance plans to provide long-term care coverage for patients with Alzheimer's and other forms of dementia ~~cover this ever-growing disenfranchised population~~. (Directive to Take Action)

RECOMMENDATION B:

Title of Resolution 110 be changed to read as follows:

LONG-TERM CARE COVERAGE FOR PATIENTS WITH DEMENTIA

HOD ACTION: Resolution 110 adopted as amended with change in title.

LONG-TERM CARE COVERAGE FOR PATIENTS WITH DEMENTIA

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)

Testimony was very supportive of the intent of Resolution 110 to address the long-term care needs of dementia patients. Clarifying amendments were proffered that suggested replacing “ever-growing disenfranchised population” with language more specific to patients with dementia. Although some speakers supported reaffirmation of AMA policy on long-term care and long-term services and supports, a preponderance of the testimony favored adoption of Resolution 110. Accordingly, your Reference Committee recommends that the resolution be adopted as amended.

- (11) RESOLUTION 116 -- MEDICARE COVERAGE OF OTC NICOTINE REPLACEMENT THERAPY

RECOMMENDATION A:

Resolution 116 be amended by addition to read as follows:

RESOLVED, That our American Medical Association advocate for over-the-counter (OTC) nicotine replacement therapies, that have been approved or cleared by the U.S. Food and Drug Administration, excluding e-cigarette product device types and 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.

RECOMMENDATION B:

Resolution 116 be adopted as amended.

HOD ACTION: Resolution 116 adopted as amended.

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)

Your Reference Committee heard testimony supportive of Resolution 116. It was noted that nicotine replacement therapy is covered through Medicaid in 15 states and online testimony noted that Medicaid allows over-the-counter (OTC) coverage as an optional benefit and the ACA includes technical carve-outs for OTC therapies, both of which establish a federal precedent. Your Reference Committee agreed that the amended language offered by the Centers for Disease Control and Prevention is consistent with existing policy on the potential harms of e-cigarette use, specifically Policy H-495.972 Electronic Cigarettes, Vaping, and Health. The resolution is also consistent with Policy H-490.916 Health Insurance and Reimbursement for Tobacco Cessation and Counseling that supports the ready availability of health insurance coverage and reimbursement for pharmacologic and behavioral treatment of nicotine dependence and smoking cessation efforts. Therefore, your Reference Committee recommends that Resolution 116 be adopted as amended.

- (12) RESOLUTION 118 -- ADVANCING ACUTE CARE AT HOME
RESOLUTION 120 – SUPPORTING PERMANENT REIMBURSEMENT OF
ACUTE CARE AT HOME

RECOMMENDATION A:

Resolution 118 be amended by addition and deletion to read as follows:

RESOLVED, That the AMA advocate for passage of federal legislation that provides permanence to the Centers for Medicare and Medicaid Services acute care at home model (Directive to Take Action); and be it further

RESOLVED, That the AMA work with interested state medical associations to identify state-level barriers to implementing and sustainably funding acute care at home, ~~to include but not be limited to: health and safety regulation applicability to services in the home, union opposition to acute care at home, and Mobile Integrated Health/Community Paramedicine limitations in states~~ (Directive to Take Action); and be it further

RESOLVED, That the AMA, in coordination with other acute care at home advocacy groups, ~~advocate that the federal government work with states to address the concerns of current state regulators~~ identify avenues for addressing state regulatory concerns (Directive to Take Action); and be it further

RESOLVED, That the AMA engage with allied health professional ~~nursing~~ organizations to share perspectives and address concerns about the benefits and challenges of acute care at home (Directive to Take Action).

RECOMMENDATION B:

Resolution 118 be adopted as amended in lieu of Resolution 120.

HOD ACTION: Resolution 118 adopted as amended in lieu of Resolution 120.

RESOLUTION 118

RESOLVED, that the AMA advocate for passage of federal legislation that provides permanence to the Centers for Medicare and Medicaid Services acute care at home model (Directive to Take Action); and be it further

RESOLVED, that the AMA work with interested state medical associations to identify state-level barriers to implementing acute care at home, to include but not be limited to: health and safety regulation applicability to services in the home, union opposition to acute care at home, and Mobile Integrated Health/Community Paramedicine limitations in states (Directive to Take Action); and be it further

RESOLVED, That the AMA, in coordination with other acute care at home advocacy groups, advocate that the federal government work with states to address the concerns of current state regulators (Directive to Take Action); and be it further

RESOLVED, That the AMA engage with nursing organizations to share perspectives and address concerns about the benefits and challenges of acute care at home. (Directive to Take Action)

RESOLUTION 120

RESOLVED, That our AMA advocate for policy making the reimbursement of Home Hospital permanent as currently enabled through the temporary Centers for Medicare & Medicaid Services Acute Hospital Care at Home waiver (Directive to Take Action); and be it further

RESOLVED, That our AMA support legislation that promotes parity between the reimbursement for Home Hospital care and traditional inpatient care amongst all payors (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts to promote the sustainability and growth of Home Hospital, including those encouraging research and innovation in the home-based acute care space. (Directive to Take Action)

Your Reference Committee heard robust testimony on Resolution 118 and Resolution 120 attesting that acute hospital care at home is a valid health care delivery model and emphasizing the need to provide permanence to the Centers for Medicare and Medicaid Services' acute care at home model, beyond its current December 31, 2024, extension. The Council on Medical Service offered amended language for Resolution 120 that your Reference Committee agreed addresses the intent of the two resolutions. The amendments to the second and third resolve clauses appropriately make them broader and more flexible. The authors of Resolution 120 testified to the importance of ensuring that physicians are adequately compensated for the care they are providing in the home hospital, thus your Reference Committee amended the second resolve clause to include sustainably funding these efforts. In the fourth resolve clause, your Reference Committee acknowledges that other allied health professional organizations in addition to nursing will be involved with the acute care at home physician-led multi-disciplinary team.

- (13) RESOLUTION 119 -- RESCINDING THE MEDICARE THREE-DAY HOSPITAL INPATIENT REQUIREMENT FOR NURSING HOME ADMISSION

RECOMMENDATION A:

Resolution 119 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association ~~request a stakeholders meeting with the Centers for Medicare and Medicaid Services~~ to advocate that the Medicare three-day hospital inpatient requirement for skilled nursing facility admissions be immediately rescinded for uniformity and safety for all Medicare recipients (Directive to Take Action).

RECOMMENDATION B:

Resolution 119 be adopted as amended.

HOD ACTION: Resolution 119 adopted as amended.

RESOLVED, That our American Medical Association request a stakeholders meeting with the Centers for Medicare and Medicaid Services to advocate that the Medicare three-day hospital inpatient requirement for skilled nursing facility admissions be immediately rescinded for uniformity and safety for all Medicare recipients. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 119, with commenters noting that the three-day rule is based on an antiquated law created in an era when the average hospital stay was 13 days. During the COVID-19 public health emergency, the three-day policy was temporarily rescinded but patient care was vastly improved.

Testimony outlined the discriminatory nature of the recent Center for Medicare and Medicaid Services decision to lift the three-day requirement for some Medicare beneficiaries but not others, highlighting the inequity inherent in the three-day policy. The Council on Medical Service noted that while they are supportive of a permanent ban of the three-day rule, only Congress has the ability to rescind it. Therefore, the Council suggested that the resolution be

amended accordingly. Your Reference Committee appreciates the clarification provided by the Council and recommends that Resolution 119 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (14) RESOLUTION 104 -- SUPPORT FOR MEDICARE EXPANSION TO WHEELCHAIR ACCESSIBILITY HOME MODIFICATIONS AS DURABLE MEDICAL EQUIPMENT

RECOMMENDATION:

Alternate Resolution 104 be adopted in lieu of Resolution 104.

RESOLVED, That our American Medical Association (AMA) recognize that for individuals for whom use of a wheelchair at home has been deemed medically necessary, home modifications, including wheelchair ramps, are also medically necessary (New HOD Policy); and be it further

RESOLVED, That our AMA help to educate patients, physicians, and other health care providers regarding available sources of funding, including but not limited to Medicaid waivers, nonprofits, loans through the U.S. Department of Housing and Urban Development, and volunteer organizations, for home modifications. (New HOD Policy)

HOD ACTION: Alternate Resolution 104 adopted in lieu of Resolution 104.

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)

Testimony on Resolution 104 was mixed, with commenters highlighting both the importance of ramps to wheelchair users and the potentially high costs of home modifications. Testimony further conveyed that home modification expenses should not be added to the budget-neutral Medicare Part B program.

An amendment was offered to support "new funding" for Medicare Part B to cover wheelchair ramps and associated home installation. Alternate Resolved clauses were also proffered asking the AMA to recognize that home modifications, such as ramps, are medically necessary only for individuals for whom using a wheelchair at home is medically necessary. Testimony was supportive of the proffered alternate language but new funding seems unlikely in the current political climate. Therefore, your Reference Committee recommends that Alternate Resolution 104 be adopted in lieu of Resolution 104.

- (15) RESOLUTION 112 -- REMOVAL OF BARRIERS TO CARE FOR LUNG CANCER SCREENING IN MEDICAID PROGRAMS

RECOMMENDATION:

Alternate Resolution 112 be adopted in lieu of Resolution 112.

RESOLVED, That our American Medical Association work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and

education to improve awareness and utilization of the screening among eligible enrollees. (New HOD Policy)

HOD ACTION: Alternate Resolution 112 adopted in lieu of Resolution 112.

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)

Testimony was very supportive of Resolution 112. Speakers highlighted the variability across state Medicaid programs in coverage of low-dose CT screening for eligible enrollees and affirmed the need to reduce barriers to screening such as patient cost-sharing and prior authorization. Testimony highlighted the need to increase access to low-dose CT screening for Medicaid enrollees at high risk for lung cancer to improve screening rates so the disease can be detected at earlier stages. A Council on Medical Service member testified that AMA advocacy for Medicaid improvements at the state level is generally carried out at the invitation of a state medical association, and offered alternate language that is consistent with AMA policy and advocacy efforts regarding Medicaid and lung cancer screening. Your Reference Committee added language to the suggested alternate Resolved clause to support increased funding for research and education and, therefore, recommends adoption of Alternate Resolution 112 in lieu of Resolution 112.

RECOMMENDED FOR REFERRAL

- (16) RESOLUTION 103 -- MOVEMENT AWAY FROM EMPLOYER-SPONSORED HEALTH INSURANCE

RECOMMENDATION:

Resolution 103 be referred.

HOD ACTION: Resolution 103 referred.

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.~~
 - be. 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.
 - cd. 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.
 - de. The public option is financially self-sustaining and has uniform solvency requirements.
 - ef. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
 - fg. 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)

Your Reference Committee heard mixed testimony regarding Resolution 103, with one commenter proffering alternate Resolved clauses to: (1) recognize inefficiencies and complexities in all health insurance systems and support models that better align incentives to facilitate access to high quality health care; (2) support movement toward a health care system that enables universal access to high quality health care; and (3) reaffirm Policy H-165.828 Health Insurance Affordability.

Some commenters who opposed Resolution 103 believed that its Resolved clauses support a government sponsored single payer health care system, with lower payments to providers and/or decreased access for patients. They noted that inefficiencies and complexities occur in all types of health care coverage, not just employer-sponsored health insurance (ESHI). There were also questions on the accuracy of the statistics provided in the whereas clauses regarding the percentage of patients dissatisfied with their ESHI plans, and one commenter presented contrasting data that the typical individual is happy with their ESHI plans. The vast majority of commenters who opposed Resolution 103 recommended referral given the complexity of the issue.

Commenters who supported Resolution 103 believed that its Resolved clauses allow additional insurance options, thereby reinforcing plurality of coverage. They also noted that Resolution 103 does not advocate against employer sponsored health insurance but allows additional insurance options for persons whose work-based insurance does not provide adequate coverage for said person or families. Commenters indicated support for resolved clause 3 but referral for resolved clauses 1 and 2.

The Council on Medical Service pointed out that the resolution does not consider many unintended consequences of the proposal, including the potential cost shift from employers to taxpayers and adverse selection. It was noted that

employers may be motivated to restructure their plans to maximize the benefits of both premium tax credits and the tax exclusion since they would have less incentive to keep premiums low for low-income workers (as long as they could avoid the penalty) since those workers could just go to the marketplace. Beyond further increasing federal costs, that could also mean that some middle-income individuals would see higher employee premiums. Therefore, the Council suggested referral to allow consideration consistent with AMA policy. Accordingly, your Reference Committee recommends referral of Resolution 103.

(17) RESOLUTION 106 -- BILLING FOR TRADITIONAL HEALING SERVICES

RECOMMENDATION:

Resolution 106 be referred.

HOD ACTION: Resolution 106 referred.

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)

Testimony on Resolution 106 was mixed. An individual proposed alternate language asking the AMA to support Medicaid payment for traditional healing services when provided in concert with physician-led health care teams. The proffered alternate Resolved clauses further asked the AMA to encourage communities and health care systems offering such services to adhere to a series of principles addressing traditional provider/facility arrangements, covered services, and qualified providers. Several individuals, and one state delegation, testified in support of the proffered substitute language.

There was also support for Resolution 106 as written, with some speakers concerned that the AMA should not support Medicaid payment for traditional American Indian and Alaska Native healing practices without further study. A Council on Medical Service member testified in favor of referral, expressing support for being inclusive of culturally relevant care while also wanting to ensure patient safety. Your Reference Committee agrees that further study is warranted and recommends that Resolution 106 be referred.

(18) RESOLUTION 108 -- SUSTAINABLE REIMBURSEMENT FOR COMMUNITY PRACTICES

RECOMMENDATION:

Resolution 108 be referred.

HOD ACTION: Resolution 108 referred.

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)

Your Reference Committee heard mostly supportive testimony on Resolution 108, with commenters acknowledging the need to address the effects of low payment on small and rural practices, including unfair advantages granted to competitors such as federally qualified health centers. Testimony outlined that AMA policy has gaps and does not address subpar payment by private payers or state and local governments. Commenters noted that private practices are critical to serve the breadth of patient needs but are closing due to lack of negotiating power.

In addition to one other commenter, the Council on Medical Service recommended referral, as the AMA has substantial policy on protecting and supporting small group medical practices and advocating for adequate payment for private practicing physicians and the AMA's broader goals of advocating for fair payment and ensuring access to health care for all patients. The Council agreed that a study is essential to uncover the extent of the problem and identify how smaller practices can unify to negotiate with the power of larger groups. Referral will achieve the intended goal while allowing the creation of one unified report instead of a series of disparate reports linked to each individual resolved clause as requested by the resolution. Accordingly, your Reference Committee recommends that Resolution 108 be referred.

RECOMMENDED FOR NOT ADOPTION

(19) **RESOLUTION 102 -- REFORMING THE MEDICARE PART B "BUY AND BILL" PROCESS TO ENCOURAGE BIOSIMILAR USE**

RECOMMENDATION:

Resolution 102 not be adopted.

HOD ACTION: Resolution 102 not adopted.

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)

Your Reference Committee heard predominantly negative testimony for Resolution 102, with one recommendation for referral. Supporters noted that Resolution 102 mirrors Medicare's existing small-molecule/generic payment policy, by reimbursing a brand-name biologic at the same price as its clinically equivalent biosimilar alternatives and will encourage direct price competition, resulting in savings and gains for physicians.

Commenters who opposed Resolution 102 were concerned about lowering payment to incentivize selection of less expensive physician-administered drugs, which runs counter to patient care and physician choice. Several commenters who were high volume prescribers stated that Resolution 102 misstates the problem, as the current system works and fixed pricing would inhibit competition. The real issue lies in the pharmacy benefit manager system, which is not "buy and bill." A unifying price would allow the insurance company to pick the lowest price and then penalize the physician for using the higher priced drug, even if it is the one more appropriate for the patient.

Testimony from the Council on Medical Service noted that biosimilars do not always come with significant discounts as most assume; therefore, this reform will not solve the problem. The Council indicated that this proposal places the onus of fixing drug prices on physicians and patients while not addressing the root problem, which is the high list price of the drugs. Accordingly, your Reference Committee recommends that Resolution not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(20) RESOLUTION 113 -- COST OF INSULIN

RECOMMENDATION:

Policies H-110.984, H-110.986, and H-110.990 be reaffirmed in lieu of Resolution 113.

HOD ACTION: Policies H-110.984, H-110.986, and H-110.990 reaffirmed in lieu of Resolution 113.

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)

Testimony on Resolution 113 was mixed. Some commenters were supportive of the concept of reducing cost-sharing for insulin to zero, while others favored reaffirmation of existing AMA policy on insulin affordability and value-based prescription drug pricing. A Council on Medical Service member noted that the Council presented a report in 2018 on insulin affordability as well as a 2016 report that established policy supporting value-based pricing for pharmaceuticals. Further, existing policy encourages payers to determine patient cost-sharing based on the clinical value of a health care service or treatment, stipulating that consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance.

A Council on Legislation member also testified in support of reaffirmation, highlighting a new \$35 cap on Medicare patients' out-of-pocket spending for insulin, enacted by the Inflation Reduction Act, and a similar \$35 cap announced by a manufacturer. The Council member stated that the AMA can monitor the new caps' impact over time and then evaluate the need for further action. Additional testimony questioned why the resolution focused solely on insulin and not on supplies and other treatments for patients with diabetes. Although some speakers recommended referral, your Reference Committee believes existing AMA policy should be reaffirmed and therefore recommends reaffirmation of Policies H-110.984, H-110.986, and H-110.990 in lieu of Resolution 113.

Insulin Affordability H-110.984

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to investigate insulin pricing and market competition and take enforcement actions as appropriate; (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies; and (3) support state and national efforts to limit the ultimate expenses incurred by insured patients for prescribed insulin. (CMS Rep. 07, A-18; Modified: Res. 118, A-22)

Incorporating Value into Pharmaceutical Pricing H-110.986

1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion. 2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. 3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size. (CMS Rep. 05, I-16;

Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20)

Cost Sharing Arrangements for Prescription Drugs H-110.990

Our AMA: 1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;

2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition; and 4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information. (CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed in lieu of Res. 105, A-13; Reaffirmed in lieu of: Res. 205, A-17; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS Rep. 07, A-18; Appended: CMS Rep. 2, I-21)

REPORT OF REFERENCE COMMITTEE B

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 9 – Council on Legislation Sunset Review of 2013 House Policies
2. Board of Trustees Report 11 – HPSA and MUA Designation for SNFs
3. Board of Trustees Report 12 – Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners
4. Resolution 224 – Advocacy Against Obesity-Related Bias by Insurance Providers
5. Resolution 225 – Regulation of “Cool/Non-Menthol” Tobacco Products
6. Resolution 241 – Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents
7. Resolution 246 – Modification of CMS Interpretation of Stark Law
8. Resolution 254 – Eliminating the Party Statement Exception in Quality Assurance Proceedings

RECOMMENDED FOR ADOPTION AS AMENDED

9. Resolution 201 – Pharmacists Prescribing for Urinary Tract Infections
10. Resolution 206 – Tribal Public Health Authority
11. Resolution 207 – Ground Ambulance Services and Surprise Billing
12. Resolution 208 – Medicaid Managed Care for Indian Health Care Providers
13. Resolution 209 – Purchased and Referred Care Expansion
14. Resolution 211 – Amending Policy H-80.999, “Sexual Assault Survivors”, to Improve Knowledge and Access to No-cost Rape Test Kits
15. Resolution 213 – Telemedicine Services and Health Equity
16. Resolution 216 – Improved Foster Care Services for Children
17. Resolution 217 – Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools
18. Resolution 218 – 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
19. Resolution 220 – Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations
20. Resolution 221 – Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool
21. Resolution 223 – Protecting Access to Gender Affirming Care

22. Resolution 226 – Vision Qualifications for Driver’s License
23. Resolution 227 – Reimbursement for Postpartum Depression Prevention
24. Resolution 228 – Reducing Stigma for Treatment of Substance Use Disorder
25. Resolution 230 – Address Disproportionate Sentencing for Drug Offenses
26. Resolution 235 – EMS as an Essential Service
27. Resolution 236 – AMA Support for Nutrition Research
28. Resolution 244 – Recidivism
29. Resolution 245 – Biosimilar/Interchangeable Terminology
30. Resolution 259 – Strengthening Supplemental Nutrition Assistance Program (SNAP)

RECOMMENDED FOR ADOPTION IN LIEU OF

31. Resolution 214 – Advocacy and Action for a Sustainable Medical Care System
Resolution 234 – Medicare PFS Updates and Grassroots Campaign
Resolution 257 – AMA Efforts on Medicare Payment Reform
32. Resolution 219 – Repealing the Ban on Physician-Owned Hospitals
Resolution 222 – Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA)
Resolution 261 – Physician Owned Hospitals
33. Resolution 237 – Prohibiting Covenants Not-to-Compete in Physician Contracts
Resolution 263 – Elimination of Non-Compete Clauses in Employment Contracts
34. Resolution 239 – Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians
Resolution 262 - Alignment of Specialty Designations for Advanced Practice Providers With Their Supervising Physicians
35. Resolution 247 – Assessing the Potentially Dangerous Intersection Between AI and Misinformation
Resolution 251 – Federal Government Oversight of Augmented Intelligence
Resolution 256 – Regulating Misleading AI Generated Advice to Patients

RECOMMENDED FOR REFERRAL

36. Resolution 202 – Support for Mental Health Courts
37. Resolution 203 – Drug Policy Reform
38. Resolution 204 – Supporting Harm Reduction
39. Resolution 240 – Attorneys’ Retention of Confidential Medical Records and Controlled Medical Expert’s Tax Returns After Case Adjudication

RECOMMENDED FOR REFERRAL FOR DECISION

40. Resolution 258 – Adjustments to Hospice Dementia Enrollment Criteria

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

41. Resolution 205 – Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness
42. Resolution 210 – The Health Care Related Effects of Recent Changes to the US Mexico Border
43. Resolution 212 – Marijuana Product Safety
44. Resolution 215 – Supporting Legislative and Regulatory Efforts against Fertility Fraud
45. Resolution 231 – Equitable Interpreter Services and Fair Reimbursement
46. Resolution 260 – Advocate to the Centers for Medicare and Medicaid Services and The Joint Commission to Redefine the Term “Provider” and Not Delete the Term “Licensed Independent Practitioner”

RECOMMENDED FOR ADOPTION

- (1) BOT 9 - COUNCIL ON LEGISLATION SUNSET REVIEW OF 2013 HOUSE POLICIES

RECOMMENDATION:

Recommendation in Board of Trustees Report 9 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 9 adopted and the remainder of the Report filed.

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.

Your Reference Committee considered Board of Trustees Report 9 and agrees with the recommendations for the policies in the Sunset Review. Your Reference Committee, therefore, recommends that the recommendations in Board of Trustees Report 9 be adopted and that the remainder of the report be filed.

- (2) BOT 11 - HPSA AND MUA DESIGNATION FOR SNFS

RECOMMENDATION:

Recommendation in Board of Trustees Report 11 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 11 adopted and the remainder of the Report filed.

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 policies, 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)

Your Reference Committee heard positive testimony in support of BOT 11. Your Reference Committee heard testimony that emphasized the need for quality care and recognized the significant role that skilled nursing facilities (SNFs) play in providing such care. Your Reference Committee notes that our existing comprehensive approach to addressing physician shortages aligns perfectly with the issues raised in the report. Testimony stated that our AMA has long been committed to tackling physician shortages in various settings, including underserved populations and specialties. Your Reference Committee heard positive testimony reinforcing our AMA's ongoing efforts and highlighting the relevance of our existing strategies addressing the specific challenges faced by SNFs. Your Reference Committee heard testimony supporting scholarship and loan repayment programs which our AMA already has policy on and which is noted in the report. Your Reference Committee recognizes the importance of these initiatives in incentivizing physicians and medical students to work in underserved areas. Testimony noted that by providing financial assistance and support, these programs effectively attract and retain healthcare professionals where they are most needed, including within SNFs. Your Reference Committee, therefore, recommends that the recommendations in Board of Trustees Report 11 be adopted and that the remainder of the report be filed.

- (3) BOT 12 - PROMOTING PROPER OVERSIGHT AND REIMBURSEMENT FOR SPECIALTY PHYSICIAN EXTENDERS AND NON-PHYSICIAN PRACTITIONERS

RECOMMENDATION:

Recommendation in Board of Trustees Report 12 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 12 adopted and the remainder of the Report filed.

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)

Your Reference Committee heard only positive testimony in support of BOT Report 12, including from the author of the original resolution. Your Reference Committee heard that medical boards in many states already license and regulate a variety of non-physicians, including physician assistants, and that medical boards in several states also jointly regulate nurse practitioners and other advanced practice registered nurses (APRN). Your Reference Committee heard support for both reaffirmation of existing AMA policy supporting regulatory oversight of physician assistants by state medical boards, and for joint licensure and regulation of APRNs by the state boards of medicine and nursing. Your Reference Committee also heard that our AMA's "Model Act to Support Physician-Led Team Based Health Care" includes language to this effect. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 12 be adopted and that the remainder of the report be filed.

(4) RESOLUTION 224 - ADVOCACY AGAINST OBESITY-RELATED BIAS BY INSURANCE PROVIDERS

RECOMMENDATION:

Resolution 224 be adopted.

HOD ACTION: Resolution 224 adopted.

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)

Your Reference Committee heard generally supportive testimony for Resolution 224. Testimony noted how important access to care for those with obesity is and how insurance companies often are biased and do not want to authorize the care needed for those who are diagnosed with obesity. Your Reference Committee heard about the important health needs of those with obesity and the alternate care options they turn to if they are not granted the care that they and their physician decide is best for their health. Therefore, your Reference Committee recommends that Resolution 224 be adopted.

(5) RESOLUTION 225 - REGULATION OF "COOL/NON-MENTHOL" TOBACCO PRODUCTS

RECOMMENDATION:

Resolution 225 be adopted.

HOD ACTION: Resolution 225 adopted.

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)

Your Reference Committee heard testimony overwhelmingly in support of Resolution 225. Your Reference Committee heard that our AMA has strong policy in support of banning menthol cigarettes and other flavored tobacco products and joined with a coalition of tobacco control stakeholders in detailed comments to this effect in response to the U.S. Food and Drug Administration’s (FDA) proposed rules banning menthol in cigarettes and cigars last year. Your Reference Committee also heard that after the state of California enacted legislation banning menthol cigarettes, tobacco companies immediately began introducing new products to the California market designed to appeal to the state’s menthol smokers by replicating the “cooling” feel of menthol cigarettes in an attempt to circumvent the new law. Your Reference Committee also heard that in March of 2023, our AMA joined with a coalition of stakeholders in a letter to the FDA urging them to immediately begin an investigation of these new products and to ensure that appropriate enforcement proceedings are initiated to prevent their continued sale. Your Reference Committee further heard that, although our AMA has already implemented the resolution’s request, Resolution 225 should be adopted so that this policy is added to our AMA’s extensive policy compendium on tobacco control and regulation. Your Reference Committee therefore recommends that Resolution 225 be adopted.

- (6) RESOLUTION 241 - ALLOW VIEWING ACCESS TO PRESCRIPTION DRUG MONITORING PROGRAMS THROUGH EHR FOR CLINICAL MEDICAL STUDENTS AND RESIDENTS

RECOMMENDATION:

Resolution 241 be adopted.

HOD ACTION: Resolution 241 adopted.

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)

Your Reference Committee heard support for Resolution 241. Your Reference Committee heard testimony that prescription drug monitoring programs (PDMP) can be helpful tools to show a patient’s or physician’s prescription history. Your Reference Committee reviewed testimony that noted the widespread use of PDMPs by physicians and other health care professionals who accessed PDMPs more than 1.1 billion times in 2021. Your Reference Committee heard that there are approximately 40 states that require physicians to use a PDMP prior to prescribing a controlled substance. Your Reference Committee heard that medical students and residents need to become accustomed to how PDMPs are incorporated into clinical practice. Your Reference Committee heard that this Resolution positions our AMA to help in whatever way necessary to remove medical students’ and residents’ barriers to using a PDMP. Your Reference Committee therefore recommends that Resolution 241 be adopted.

- (7) RESOLUTION 246 - MODIFICATION OF CMS INTERPRETATION OF STARK LAW

RECOMMENDATION:

Resolution 246 be adopted.

HOD ACTION: Resolution 246 adopted.

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)

Your Reference Committee heard testimony in support of Resolution 246. Testimony noted that this Resolution aligns with current AMA policy while adding a new aspect to our AMA advocacy by requesting that the Center for Medicare and Medicaid Services (CMS) retract its determination that delivery of medicine to a patient using the United States Postal Service, a commercial package service, or a trusted surrogate violates the in-office exception of the Stark Law. Testimony also supported advocacy for legislation to clarify that a surrogate may deliver medicine dispensed at a physician-owned pharmacy without being in violation of the Stark Law. Accordingly, your Reference Committee recommends that Resolution 246 be adopted.

(8) RESOLUTION 254 - ELIMINATING THE PARTY STATEMENT EXCEPTION IN QUALITY ASSURANCE PROCEEDING

RECOMMENDATION:

Resolution 254 be adopted.

HOD ACTION:

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)

Your Reference Committee heard testimony in support of Resolution 254, highlighting the importance of addressing the challenges faced by quality assurance (QA) groups and the impact of legal decisions on QA proceedings. Your Reference Committee heard testimony emphasizing the need to protect the effectiveness of QA proceedings and the timeliness of the issue at hand. Your Reference Committee heard participants express concerns about the discoverability of statements, which can lead to a decrease in the efficacy of QA processes and increase the risk of liability. Your Reference Committee heard recognition for the need for peer review and QA to be conducted in good faith, with protections and privileges afforded by law. Therefore, your Reference Committee recommends that Resolution 254 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

(9) RESOLUTION 201 - PHARMACISTS PRESCRIBING FOR URINARY TRACT INFECTIONS

RECOMMENDATION A:

The first Resolve of Resolution 201 be amended by addition and deletion to read as follows:

Resolved, That our AMA collaborate with relevant stakeholders including state and specialty societies to oppose legislation or regulation allowing pharmacists to test, diagnose and treat ~~urinary tract infections~~ medical conditions. (Directive to Take Action)

RECOMMENDATION B:

The second Resolve of Resolution 201 be deleted:

~~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)~~

RECOMMENDATION C:

Resolution 201 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 201 be changed to read as follows:

OPPOSITION TO PHARMACISTS TESTING, DIAGNOSING, AND TREATING MEDICAL CONDITIONS

HOD ACTION: Resolution 201 adopted as amended with a change of title.

OPPOSITION TO PHARMACISTS TESTING, DIAGNOSING, AND TREATING MEDICAL CONDITIONS

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)

Your Reference Committee heard testimony largely in support of Resolution 201. Testimony in support of the Resolution noted that legislation to allow pharmacists to test for and treat urinary tract infections has been proposed across the country, and that antimicrobial resistance associated with overuse or misuse of antibiotics used to treat infections is a public health concern. Your Reference Committee also heard concerns that pharmacists may not recognize comorbidities if allowed to diagnose and treat urinary tract infections and that prescribing medications constitutes the practice of medicine and is outside pharmacists' scope of practice. Some testimony recommended reaffirmation of existing AMA policy that opposes the practice of medicine by nonphysicians and opposes the prescribing of medications by pharmacists without a valid order by a physician or without physician supervision. Further, your Reference Committee received a proposed amendment that would expand the scope of this Resolution to oppose legislation and regulation that allows pharmacists to test for, diagnose, and treat any medical condition, to include infections. Recognizing that the diagnosis and treatment of any medical condition constitutes the practice of medicine, and because this Resolution would strengthen existing policy and align with our AMA's advocacy, your Reference Committee recommends that Resolution 201 be adopted as amended.

(10) RESOLUTION 206 - TRIBAL PUBLIC HEALTH AUTHORITY

RECOMMENDATION A:

The first Resolve of Resolution 206 be deleted.

~~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~~

RECOMMENDATION B:

The second Resolve of Resolution 206 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support ~~make a suggestion to~~ the Department of Health and Human Services ~~to issuing develop sub-agency guidance, through the Centers for Disease Control and Prevention and the Indian Health Service, (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

RECOMMENDATION C:

The third Resolve of Resolution 206 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~encourage~~ support 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)

RECOMMENDATION D:

Resolution 206 be adopted as amended.

HOD ACTION: Resolution 206 adopted as amended.

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)

Your Reference Committee heard mixed testimony on Resolution 206. Your Reference Committee heard that American Indian and Alaska Native (AI/AN) Tribes and Villages (Tribal Nations) and Tribal Epidemiology Centers (TECs) are "public health authorities" under federal law and, as such, have the legal authority to collect, receive, and disseminate public health data to respond to public health threats. Your Reference Committee further heard that, despite this legal authority, these entities have had difficulty accessing Centers for Disease Control and Prevention (CDC) and Indian Health Services (IHS) data, as well as state and local data, especially during the COVID-19 pandemic, when it was reported that county and state public health agencies refused to share case and mortality data with Tribal Nations and TECs in California and the Great Plains area. Testimony also stated that in a 2022 study, the US Government Accounting Office (GAO) reaffirmed TECs status as public health authorities. Your Reference Committee further heard that the first resolve asks our AMA to advocate to reaffirm AI/AN Tribal Nations and TECs' status as public health authorities; however, your Reference Committee also heard that our AMA does not need to advocate for reaffirmation of Tribal Nations and TECs' status as public health authorities, since existing law provides such authority, which the GAO study confirmed, and which Reference Committee testimony confirmed. Your Reference Committee also heard an amendment offered to slightly amend the language in resolves 2 and 3 for our AMA to support the issuance of Department of Health and Human Services guidance on data-sharing and to support the use of data-sharing agreements between local and state public health departments and AI/AN Tribal Nations and TECs. Your Reference Committee acknowledges the supplemental information provided by the CDC, including

information that the CDC is currently working on guidance called for by the GAO report on data sharing. Therefore, your Reference Committee recommends that Resolution 206 be adopted as amended.

(11) RESOLUTION 207 - GROUND AMBULANCE SERVICES AND SURPRISE BILLING

RECOMMENDATION A:

Resolution 207 be adopted as amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~oppose surprise billing practices for~~ support full insurance coverage for all costs associated with ground ambulance services.

RECOMMENDATION B:

Resolution 207 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 207 be changed to read as follows:

INSURANCE COVERAGE OF GROUND AMBULANCE SERVICES

HOD ACTION: Resolution 206 adopted as amended with a change of title.

INSURANCE COVERAGE OF GROUND AMBULANCE SERVICES

RESOLVED, That our American Medical Association oppose surprise billing practices for ground ambulance services. (New HOD Policy)

Your Reference Committee heard mixed testimony regarding Resolution 207, which focused on the need to extend patient protections to ground ambulance services and address surprise billing. Your Reference Committee heard testimony in favor of the Resolution, emphasizing that extending patient protections to ground ambulance services is timely and necessary. Your Reference Committee heard proponents testify that it is crucial to ensure that patients using emergency ground transportation are not burdened with exorbitant out-of-pocket costs. Your Reference Committee heard testimony in favor of aligning ground ambulance services with existing patient protection measures applied to other medical services. Your Reference Committee heard testimony about the urgency for our AMA to engage in advocacy. On the other hand, your Reference Committee heard opposing testimonies expressing concerns about the unintended consequences of the Resolution. Your Reference Committee heard arguments that excluding ground ambulances from the No Surprises Act was intentional due to the nature of services provided by municipal and local authorities. Your Reference Committee heard concerns that subjecting ground ambulances to the same regulations as other medical services could jeopardize access to emergency transportation, particularly in areas where alternate options are limited. Your Reference Committee heard additional concerns about the potential negative impact on patient care and access if the Resolution were to pass without adequately addressing these issues. Your Reference Committee heard testimony in favor of amended language that advocates for full insurance coverage for ground ambulance services. Your Reference Committee heard testimony that the responsibility for addressing the issue of surprise billing should lie with insurance companies, narrow networks, and lack of coverage, rather than placing it on physicians or ground ambulance services. Your Reference Committee heard about the importance of ensuring that patients are protected from financial burdens of emergency medical services and that insurance companies should be held accountable for providing adequate coverage for ground ambulance services. Accordingly, your Reference Committee recommends that Resolution 207 be adopted as amended.

(12) RESOLUTION 208 - MEDICAID MANAGED CARE FOR INDIAN HEALTH CARE PROVIDERS

RECOMMENDATION A:

The first Resolve of Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~urge~~ support 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 ~~in compliance~~ complying with their legal obligations to Indian health care providers (New HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~collaborate with other stakeholders to~~ encourage state Medicaid agencies to follow the Centers 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 New HOD Policy)~~

RECOMMENDATION C:

Resolution 208 be adopted as amended.

HOD ACTION: Resolution 208 adopted as amended.

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)

Your Reference Committee heard mostly supportive testimony about Resolution 208. Your Reference Committee heard that state Medicaid programs or their contracted Managed Care Organizations (MCOs) must follow regulatory Indian Health Care Medicaid Managed Care Provisions that protect the rights of Indian Health Care Providers

(IHCPs). Your Reference Committee also heard that a Managed Care Subcommittee of the Tribal Technical Advisory Group from the Centers for Medicare and Medicaid Services identified several issues negatively impacting the availability of health care services offered by IHCPs to American Indians/Alaska Natives covered by Medicaid, such as denial of claims, incorrect payment, and inadequate state oversight of MCOs. Your Reference Committee further heard that greater compliance with regulations governing Indian Health Care Medicaid Managed Care Provisions would improve the availability of services offered by IHCPs. Your Reference Committee heard that the Resolution as drafted was too prescriptive and suggested amendments would provide our AMA with more flexibility to implement the Resolution's goals of improving availability of health care services to American Indians and Alaska Natives covered under Medicaid. Accordingly, your Reference Committee recommends that Resolution 208 be adopted as amended.

(13) RESOLUTION 209 - PURCHASED AND REFERRED CARE EXPANSION

RECOMMENDATION A:

The first Resolve of Resolution 209 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate ~~to Congress to 1)~~ for increased funding to the Indian Health Service Purchased/Referred Care Program and to the Urban Indian Health Program to enable the programs to fully meet the healthcare needs of American Indian/Alaska Native (AI/AN) patients. ~~and 2) expand eligibility to patients served by Urban Indian Health Programs (Directive to Take Action New HOD Policy); and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 209 be deleted.

~~RESOLVED, That our AMA encourage nonprofit hospitals to allocate community benefit dollars to increase access to specialty care to patients referred from Indian Health Service, Tribal Programs, and Urban Indian Health Programs. (New HOD Policy)~~

RECOMMENDATION C:

Resolution 209 be adopted as amended.

HOD ACTION: Resolution 209 adopted as amended.

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)

Your Reference Committee heard mostly positive testimony in support of Resolution 209. Your Reference Committee heard that the Indian Health Service (IHS) is underfunded relative to other federal health programs, especially the Purchased/Referred Care Program and Urban Indian Health Program. Your Reference Committee also heard that the Purchased/Referred Care Program, a non-entitlement referral program that may cover medical and dental care provided away from an IHS or Tribal Health Program, has numerous rules and restrictions that prevent Urban Indian Health Programs from participating. Your Reference Committee further heard that IHS, Tribal, and Urban Indian Health Programs are often limited to primary care services due to funding limitations, facility constraints, and other

factors and that American Indian/Alaska Native (AI/AN) health care needs, particularly specialty care, are not being adequately met. Your Reference Committee heard testimony offering an amendment to the first resolve. Your Reference Committee also heard that community benefit dollars from non-profit hospitals have the potential to increase access to comprehensive, high-quality specialty care for AI/AN patients in states with large AI/AN populations. However, your Reference Committee heard opposition to the second resolve noting that our AMA does not have a history of involvement in directing nonprofit hospitals how to allocate community benefit dollars. Your Reference Committee further heard that our AMA has existing policy urging Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service. Testimony also noted that our AMA's advocacy should not be limited "to Congress" and that this phrase should be deleted to allow greater flexibility. Accordingly, your Reference Committee recommends that Resolution 209 be adopted as amended.

- (14) RESOLUTION 211 - AMENDING POLICY H-80.999, "SEXUAL ASSAULT SURVIVORS", TO IMPROVE KNOWLEDGE AND ACCESS TO NO-COST RAPE TEST KITS

RECOMMENDATION A:

Resolution 211 be adopted as amended by addition and deletion to read as follows:

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.
6. Our AMA supports the implementation of a national database of Sexual Assault

Nurse Examiner and Sexual Assault Forensic Examiner providers. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 211 be adopted as amended.

HOD ACTION: Resolution 211 adopted as amended.

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: (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)

Your Reference Committee heard mostly positive and passionate testimony on Resolution 211. Your Reference Committee heard that sexual violence is a public health concern that affects every community and often has lasting impacts on health and well-being. Your Reference Committee further heard that despite the intention of the Violence Against Women Act (VAWA) to provide no-cost rape kits to all survivors of sexual violence, some survivors still face out-of-pocket charges for minimum standard rape kit services as well as other medical care that takes place following a sexual assault. Your Reference Committee heard that the cost of rape test kits is not covered by all states if the provider administering the examination is not a registered Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examiner (SAFE), and that only a fraction of hospitals in the U.S. have a trained forensic examiner such as a SANE. Your Reference Committee further heard that information about the availability of SANES/SAFEs is currently limited and existing databases are only available in certain areas. Your Reference Committee also heard that creating and ensuring accessibility to a national database of SANE/SAFE providers would allow all victims to quickly access information on where and how to receive a time-sensitive, no-cost medical forensic examination, especially for historically minoritized and underserved populations. Your Reference Committee also heard that current AMA policy should be amended to add AMA support for such a database. However, your Reference Committee heard that the change to existing policy that this Resolution asks for was included in last year’s reauthorization of VAWA, which was enacted as part of the 2022 Consolidated Appropriations Act. Your Reference Committee heard that the reauthorized VAWA supports the creation of the first government-sanctioned database that would identify where Sexual Assault Nurse Examiners are located. Your Reference Committee further heard that the law also requires the U.S. Department of Health and Human Services to establish a grant program to promote the training of sexual assault

forensic examiners and to establish a National Continuing and Clinical Education Pilot Program for sexual assault forensic examiners, sexual assault nurse examiners, and other individuals who perform medical forensic examinations. Therefore, your Reference Committee recommends that Resolution 211 be adopted as amended.

(15) RESOLUTION 213 - TELEMEDICINE SERVICES AND HEALTH EQUITY

RECOMMENDATION A:

The first Resolve of Resolution 213 be deleted.

~~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~~

RECOMMENDATION B:

The second Resolve of Resolution 213 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA encourage policymakers to recognize research to determine the scope and circumstances for underserved populations including seniors and patients with complex health conditions with the aim to ensure that these patients have the technology-use training needed to maximize the benefits of telehealth and its potential to improve health outcomes 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. (Directive to Take Action)~~

RECOMMENDATION C:

Resolution 213 be adopted as amended.

RECOMMENDATION D:

That AMA Policies H-480.937 and H-480.946 be reaffirmed.

HOD ACTION: Resolution 213 adopted as amended and AMA Policies H-480.937 and H-480.946 reaffirmed.

~~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. (Directive to Take Action)~~

Your Reference Committee heard mixed testimony on Resolution 213. Your Reference Committee heard testimony that our AMA remains on the forefront on permanent widespread equitable solutions as it relates to the delivery of telehealth services. Advocacy efforts are occurring simultaneously at both the federal and state levels. Testimony highlighted that our AMA has advocated tirelessly and continues to lead on pushing for permanent telehealth flexibilities beyond the expiration of the Public Health Emergency and was pleased to see a clean extension of telehealth flexibilities granted until December 31, 2024, included in the Consolidated Appropriations Act (CAA) of 2023. Prior to the passage of the CAA, our AMA was also pleased to see successful advocacy efforts in the final

published Physician Fee Schedule for CY 2023, wherein similar extensions were granted. Your Reference Committee also heard testimony in support of the importance of payment parity for telehealth services. Your Reference Committee also heard testimony that based on existing AMA policy, our AMA will continue advocating for improved digital literacy efforts such that patients of varying ages, educational levels, ability levels, and cultural backgrounds may be able to fully embrace and appreciate the usefulness of telemedicine. Your Reference Committee heard that our AMA already has stronger existing policy that addresses the asks in the first resolve clause and as such existing AMA policy should be reaffirmed. Therefore, your Reference Committee recommends that Resolution 213 be adopted as amended and that existing AMA policies H-480.937 and H-480.946 be reaffirmed.

Addressing Equity in Telehealth H-480.937

Our AMA:

- (1) recognizes access to broadband internet as a social determinant of health;
- (2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;
- (3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;
- (4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;
- (5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;
- (6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;
- (7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
- (8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and
- (9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

Coverage of and Payment for Telemedicine H-480.946

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

- a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
 - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
 - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
 - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

- b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.

- c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
 - d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
 - e) The delivery of telemedicine services must be consistent with state scope of practice laws.
 - f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
 - g) The standards and scope of telemedicine services should be consistent with related in-person services.
 - h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
 - i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
 - j) The patient's medical history must be collected as part of the provision of any telemedicine service.
 - k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
 - l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
 - m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.
2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.
 3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
 4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
 5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
 6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
 7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

(16) RESOLUTION 216 - IMPROVED FOSTER CARE SERVICES FOR CHILDREN

RECOMMENDATION A:

The first Resolve of Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage and support state, territorial, and tribal activities to implement changes to the child welfare system directed toward ~~safely~~ keeping children with their families when appropriate and the children's safety is assured (New HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support federal and state efforts to expand access to

evidence-based ~~treatment, counseling, mental health services, substance use disorder treatment, in-home parent skills-based services, and other services which can prevent foster care and to keep families safely together in lieu of foster care for at-risk families in an effort to prevent family separation,~~ including mental health, substance use disorder treatment, and in-home parent skills-based services (~~Directive to Take Action~~New HOD Policy); and be it further

RECOMMENDATION C:

The third Resolve of Resolution 216 be deleted.

~~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 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

RECOMMENDATION D:

The fourth Resolve of Resolution 216 be deleted.

~~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 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

RECOMMENDATION E:

The fifth Resolve of Resolution 216 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA urge the development and promotion of support government maintenance 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)~~

RECOMMENDATION F:

Resolution 216 be adopted as amended.

HOD ACTION: Resolution 216 adopted as amended.

RESOLVED, That our AMA 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)

Your Reference Committee heard mixed testimony on Resolution 216. Your Reference Committee heard that the goal of the 2018 federal law (the Family First Prevention Services Act) on the child welfare system is to keep children safely with their families to avoid the trauma that results when children are placed in out-of-home care. Your Reference Committee further heard that implementation of this Act has been varied and additional funding is required for administration of the Act in addition to adoption of improved foster care placement avoiding residential placement where possible. Your Reference Committee heard however, that while well-intentioned, parts of this Resolution are already supported through AMA policy and advocacy activities, are outside our AMA's area of expertise, or are already called for in federal legislation, and that amendments are in order to reflect this. Testimony noted the need for amendments to Resolution 216 and specifically highlighted that the asks contained in the second resolve clause are already covered by the asks in the first resolve clause. Therefore, your Reference Committee recommends that Resolution 216 be adopted as amended.

- (17) RESOLUTION 217 - INCREASE ACCESS TO NALOXONE IN SCHOOLS INCLUDING BY ALLOWING STUDENTS TO CARRY NALOXONE IN SCHOOLS

RECOMMENDATION A:

The first Resolve of Resolution 217 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourage states, ~~including communities, and educational settings school districts therein,~~ to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications naloxone readily accessible to school staff, and teachers, and students to prevent opioid overdose deaths in educational settings on school campuses (New HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 217 be deleted.

~~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)~~

RESOLVED, that our AMA encourage states, communities, and educational settings to remove barriers to students carrying safe and effective overdose reversal medications.

RECOMMENDATION C:

Resolution 217 be amended by addition of a new Resolve clause.

RESOLVED, that our AMA study and report back on issues regarding student access to safe and effective overdose reversal medications.

RECOMMENDATION D:

Resolution 217 be adopted as amended.

RECOMMENDATION E:

The title of Resolution 217 be changed to read as follows:

**INCREASE ACCESS TO SAFE AND EFFECTIVE OVERDOSE REVERSAL
MEDICATIONS IN EDUCATIONAL SETTINGS**

HOD ACTION: Resolution 217 adopted as amended with a change of title.

**INCREASE ACCESS TO SAFE AND EFFECTIVE OVERDOSE REVERSAL
MEDICATIONS IN EDUCATIONAL SETTINGS**

RESOLVED, that our AMA 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

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)

Your Reference Committee heard strong support for the underlying intent of Resolution 217 to increase access to naloxone to help prevent opioid-related overdose. Your Reference Committee heard that AMA policy (Increasing Availability of Naloxone H-95.932) already provides for support of naloxone in schools “where permitted by law.” Testimony highlighted that, with the trajectory of the epidemic killing young people, there is a great need to increase access to naloxone. Your Reference Committee heard about the importance of expanding the scope of this Resolution to include other substances for which there are safe and effective reversal agents and your Reference Committee was offered amendments to this effect. Your Reference Committee considered additional background information that acknowledged CDC data showing that “15% of high school students reported having ever used select illicit or injection drugs (i.e., cocaine, inhalants, heroin, methamphetamines, hallucinogens, or ecstasy); and “14% of students reported misusing prescription opioids.” Your Reference Committee heard strong support for increasing access to naloxone in all educational settings—vocational schools, trade schools, colleges, and universities. However, your Reference Committee heard testimony expressing concern about the age children of who might be authorized to carry naloxone. Your Reference Committee heard supportive testimony for “children” and other young people to be trained on how to use naloxone before being able to carry it in schools. Your Reference Committee also heard testimony expressing concern about whether states permit young people to carry naloxone. Your Reference Committee did not hear testimony about the appropriate age for carrying naloxone, the role of parental consent, the training that would be most beneficial or other considerations that may be different for young people compared to adults. Your Reference Committee received amendments to 217 that would broaden access to additional educational institutions. However, due to the mixed testimony received, your Reference Committee recommends that the question of age, education, and training considerations for those under 18 years of age requires further study. Therefore, your Reference Committee recommends that Resolution 217 be adopted as amended.

- (18) RESOLUTION 218 - 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

RECOMMENDATION A:

Resolution 218 to be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association, ~~in accordance with 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 establishment and enforcement of legislation and/or 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 that ensure only physicians supervise the provision of emergency care services in an emergency departments by nurse practitioners. (Directive to Take Action)

RECOMMENDATION B:

Resolution 218 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 218 be changed to read as follows:

PROMOTING SUPERVISION OF EMERGENCY CARE SERVICES IN EMERGENCY DEPARTMENTS BY PHYSICIANS

HOD ACTION: Resolution 218 adopted as amended with a change of title.

PROMOTING SUPERVISION OF EMERGENCY CARE SERVICES IN EMERGENCY DEPARTMENTS BY PHYSICIANS

RESOLVED, That our American Medical Association, in accordance with 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)

Your Reference Committee heard an amendment proposed by the author of Resolution 218 and heard testimony in support of the proposed amendment. The amended language expands the breadth of the Resolution by calling upon our AMA to advocate for laws and regulations ensuring that physicians supervise emergency services and removes statements requiring that our AMA take enforcement action against entities like health systems and individual physicians. Testimony in support of the amended Resolution cited concerns regarding the growing trend of nurse practitioners supervising emergency departments, including that such practices put patients at risk because the education and training of nurse practitioners does not prepare them to supervise emergency services outside the context of physician-led teams. Your Reference Committee heard that Resolution 218 is supported by AMA's existing scope of practice policy, which opposes the independent practice of medicine by nonphysicians in all practice settings. Your Reference Committee agrees with the proposed amendment, however notes that AMA policy generally does not reference the policies of external organizations, as such policies may change. Your Reference Committee therefore recommends that Resolution 218 be adopted as amended.

- (19) RESOLUTION 220 - COVERAGE OF ROUTINE COSTS IN CLINICAL TRIALS BY MEDICARE ADVANTAGE

RECOMMENDATION A:

Resolution 220 be amended by addition of a second Resolve clause to read as follows:

RESOLVED, That our AMA advocate for the Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage Organizations (MAOs) to communicate and coordinate the payment for services associated with participation in clinical trials, covered under the Clinical Trials National Coverage Determination 310.1, and to ensure that physicians and non-physician providers are paid directly in order to eliminate the requirement that patients seek reimbursement for billed services; and be it further

RECOMMENDATION B:

Resolution 220 be amended by addition of a third Resolve clause to read as follows:

RESOLVED, That our AMA takes the position that Medicare Advantage Organizations (MAOs) and their participating physicians shall actively encourage patients to enroll in clinical trials.

RECOMMENDATION C:

Resolution 220 be adopted as amended.

HOD ACTION: Resolution 220 adopted as amended.

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)

Your Reference Committee heard testimony in support of Resolution 220 as amended, which focuses on addressing the confusion and delays faced by patients when transitioning from commercial insurance to Medicare and the impact it has on patients' access to clinical trials. Your Reference Committee heard testimony that emphasized the need to address this policy issue to ensure timely access to clinical trials for patients. Your Reference Committee heard testimony highlighting the confusion surrounding the switch to Medicare, with the initial consultation being out of pocket and causing delays. This delay often causes problems that impact the ability for patients to participate in clinical trials. The testimonies emphasized that this needs to be addressed to prevent such delays. Your Reference Committee heard broad support for mitigating these challenges and ensuring patients have the opportunity to participate in clinical trials. Accordingly, your Reference Committee recommends that Resolution 220 be adopted as amended.

- (20) RESOLUTION 221 - FENTANYL TEST STRIPS AS A HARM REDUCTION AND OVERDOSE PREVENTION TOOL

RECOMMENDATION A:

Resolution 221 be adopted as amended by addition and deletion to read as follows:

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 fentanyl test strips (FTS) and other testing strips, devices or testing equipment used in identifying or analyzing whether a substance contains fentanyl or other adulterants from the legal definition of drug paraphernalia.

32. 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.

43. 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.

54. 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.

65. 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.

76. 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, and education and training on, the use of FTS use by patients, as well as training in FTS use, by pertinent professionals.~~ (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 221 be adopted as amended.

HOD ACTION: Resolution 221 adopted as amended.

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)

Your Reference Committee heard supportive testimony for Resolution 221. Your Reference Committee agrees with testimony that this Resolution is a positive extension of current AMA policy. Your Reference Committee was pleased to hear of our AMA’s ongoing support for harm reduction initiatives, including for decriminalization of fentanyl test strips. Testimony noted that policy should account for additional adulterants, such as xylazine, that might contaminate the illicit drug supply and that Resolution 221 should be amended to account for these additional adulterants. Your Reference Committee heard that more robust surveillance of the illicit drug supply would help identify where harm reduction initiatives could be enhanced to save lives. Your Reference Committee, therefore, recommends that Resolution 221 be adopted as amended.

(21) RESOLUTION 223 - PROTECTING ACCESS TO GENDER AFFIRMING CARE

RECOMMENDATION A:

The first Resolve of Resolution 223 be deleted.

~~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~~

RECOMMENDATION B:

The second Resolve of Resolution 223 be deleted.

~~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~~

RECOMMENDATION C:

The third Resolve of Resolution 223 be deleted.

~~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~~

RECOMMENDATION D:

The fourth Resolve of Resolution 223 be deleted.

~~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~~

RECOMMENDATION E:

The fifth Resolve clause of Resolution 223 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend policy H-185.927, “Clarification of Medical Necessity for 16 Treatment of Gender Dysphoria,” by insertion and deletion as follows:

Clarification of ~~Medical Necessity~~ Evidence-Based Gender-Affirming Care for Treatment of Gender Dysphoria, H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria and 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 work with state and specialty societies and other interested stakeholders to:

- A) advocate for federal, state, and local laws and policies to protect access to evidence-based ~~provide medically necessary~~ care for gender dysphoria and 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.~~
- B) Oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
- C) Support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, gender-affirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
- D) Communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence. (Modify Current HOD Policy)

RECOMMENDATION F:**Resolution 223 be adopted as amended.****HOD ACTION: Resolution 223 adopted as amended.**

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 16 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 dysphoria and 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 dysphoria and 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)

Your Reference Committee heard testimony supporting the goals of Resolution 223. Testimony expressed frustration at recent legislative actions that threaten the care and health of transgender and gender diverse patients and urged our AMA to continue to oppose the criminalization of evidence-based care. Your Reference Committee heard testimony in support of amended language to help refine the Resolution while maintaining the integrity of the original requests. Testimony also asked for there to be an emphasis on evidence-based care. Therefore, your Reference Committee recommends that Resolution 223 be adopted as amended.

(22) RESOLUTION 226 - VISION QUALIFICATIONS FOR DRIVER’S LICENSE

RECOMMENDATION A:**Resolution 226 be amended by addition and deletion to read as follows:**

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~~ support efforts to make recommendations on

standardized vision requirements for unrestricted and restricted driver's licensing privileges. ~~(Directive to Take Action)~~ (New HOD Policy)

RECOMMENDATION B:

Resolution 226 be adopted as amended.

HOD ACTION: Resolution 226 adopted as amended.

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)

Your Reference Committee heard limited but supportive testimony on Resolution 226. Your Reference Committee heard that current vision requirements for operating motor vehicles may be outdated. Your Reference Committee further heard that there are data to recommend reconsideration of visual acuity standards in many states and studies have shown that drivers with visual acuity less than 20/50 can be safe and competent drivers. Testimony also highlighted that having an automatic reporting of a failed vision test to the Department of Motor Vehicles could cause individuals to not go and see their ophthalmologist resulting in negative health outcomes. Your Reference Committee also heard, however, that simplifying the Resolution to make it a policy statement would provide more flexibility to staff while still meeting the goals of the Resolution. Therefore, your Reference Committee recommends that Resolution 226 be adopted as amended.

- (23) RESOLUTION 227 - REIMBURSEMENT FOR POSTPARTUM DEPRESSION PREVENTION

RECOMMENDATION A:

Resolution 227 be amended by addition and deletion to read as follows:

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~~ Persons Who are Pregnant or in a Postpartum State H-420.953

Our AMA: (1) supports improvements in current mental health services ~~for women~~ during pregnancy and postpartum periods; (2) supports advocacy for inclusive insurance coverage of and sufficient payment for 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 screening and prevention services to be recognized as the standard of care for all federally-funded health care programs for persons who are pregnant women or in a postpartum state. (Modify Current HOD Policy)

RECOMMENDATION B:**Resolution 227 be adopted as amended.****HOD ACTION: Resolution 227 adopted as amended.**

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)

Your Reference Committee heard mostly supportive on Resolution 227. Your Reference Committee heard about the maternal health crisis that is currently happening in this country and the importance of providing coverage for postpartum mental health care services, including postpartum depression. However, strong testimony highlighted that our AMA already has existing policy in this space that is broad and has allowed our AMA to effectively advocate for postpartum mental health coverage. Testimony stated that our AMA has supported legislation that would provide additional research and coverage for maternal mental health. Moreover, your Reference Committee heard that our AMA has effectively and consistently advocated for additional coverage and support for maternal health care with Congress and the Administration. However, your Reference Committee heard that amendments to current policy were needed to expand policy to ensure more inclusive language and to highlight the importance of making postpartum depression screening and prevention services the standard of care. Therefore, your Reference Committee recommends that Resolution 227 be adopted as amended.

- (24) RESOLUTION 228 - REDUCING STIGMA FOR TREATMENT OF SUBSTANCE USE DISORDER

RECOMMENDATION A:

AMA Policy D-95.968 be amended by addition and deletion to read as follows:

Support the Elimination of Barriers to Evidence-Based Treatment for Substance Use Disorders ~~Medication-Assisted Treatment for Substance Use Disorder~~ D-95.968

1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medications for opioid use disorder (MOUD) and other evidence-based options as ~~medication-assisted treatment is a~~ first-line treatments for this chronic medical disease.

2. Our AMA supports further research into how primary care practices can implement MOUD ~~medication-assisted treatment (MAT)~~ into their practices and disseminate such research in coordination with primary care specialties.

3. The AMA Substance Use and Pain Care Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.
5. Our AMA supports increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders.

RECOMMENDATION B:

AMA Policy D-95.968 be adopted as amended in lieu of Resolution 228.

HOD ACTION: AMA Policy D-95.968 adopted as amended in lieu of Resolution 228.

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)

Your Reference Committee heard limited but supportive testimony for Resolution 228. Your Reference Committee heard that access to affordable transportation is a barrier to evidence-based treatment for individuals with a substance use disorder (SUD)—and many other use disorders or mental illness. Testimony stated that transportation to primary care and medical services, in general, is a challenge for many of our patients. Your Reference Committee heard that many states have options for non-emergency transportation for SUD care. Testimony stated that while the intent of the Resolution is positive, it is too limited. Your Reference Committee heard that our AMA should support all efforts to increase access to evidence-based care for SUD treatment. Testimony highlighted that if health insurers offer transportation for medical care, they should be required to provide comparable coverage for behavioral health care, including for mental health and substance use disorders. Testimony also noted that our AMA already has existing AMA policy that is on point and that should be expanded to fulfil the requests contained in this Resolution. Therefore, your Reference Committee recommends that existing AMA policy D-95.968 be adopted as amended in lieu of Resolution 228.

- (25) RESOLUTION 230 - ADDRESS DISPROPORTIONATE SENTENCING FOR DRUG OFFENSES

RECOMMENDATION A:

The first Resolve of Resolution 230 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~actively lobby support for~~ federal and state ~~legislation efforts aimed at to eliminating~~ the national crack and powder cocaine sentencing disparity (from 18:1 to 1:1) and apply ~~them~~ ~~retroactively~~ to those already convicted or sentenced (Directive to Take Action); ~~and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 230 be deleted.

~~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)~~

RECOMMENDATION C:**Resolution 230 be adopted as amended.****HOD ACTION: Resolution 230 adopted as amended.**

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)

Your Reference Committee heard mixed testimony on Resolution 230. Testimony highlighted support for the first resolve of this Resolution. Your Reference Committee heard about the fundamental unfairness regarding the disproportionate and inequitable nature of judicial sentencing of individuals convicted of crimes relating to crack cocaine compared to powdered cocaine. Your Reference Committee also heard that the US Attorney General has already taken action to remove disparities. Your Reference Committee heard that the first resolve is sound policy to reduce inequities—and that such inevitably have adverse public health effects. However, your Reference Committee heard that the second resolve goes beyond the expertise of our AMA. Your Reference Committee heard that our AMA’s experience does not provide us with the necessary expertise to properly reach a decision as to what constitutes “excessive” or what the specific parameters are for “low-level” drug crimes. Your Reference Committee was not sure whether these questions merited referral given the mixed testimony on one hand and the limited testimony about criminal sentencing specifics on the other. Your Reference Committee is mindful that specific detail is essential for our AMA to appropriately implement such a policy. Your Reference Committee, therefore, recommends that Resolution 230 be adopted as amended.

(26) RESOLUTION 235 - EMS AS AN ESSENTIAL SERVICE

RECOMMENDATION A:**The third Resolve of Resolution 235 be deleted.**

~~RESOLVED, That our AMA advocate for federal funding of Emergency Medical Services as an essential service. (Directive to Take Action)~~

RECOMMENDATION B:**Resolution 235 be adopted as amended.****HOD ACTION: Resolution 235 adopted as amended.**

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)

Your Reference Committee heard limited testimony on Resolution 235. Your Reference Committee heard support for the first two resolve clauses, specifically that emergency medical services (EMS) should be considered an essential service given the critical role of EMS in providing life-saving care and transportation to patients. Your Reference Committee also heard that there is an impending shortage of EMS which can be addressed by declaring EMS an essential service and providing funding at the state and federal level. However, your Reference Committee also heard that the third resolve clause should not be adopted. Essential health services are broad categories and do not mention specific services. As such, a single service should not be placed here. Testimony stated that advocating for emergency medical services to be an essential health benefit will be limiting and will place one service over others that are also universally needed. Additionally, your Reference Committee heard that funding should be advocated for across the board not just for one specialty. Your Reference Committee heard that the author of the resolution supported a proffered amendment to strike the third resolve clause. As such, your Reference Committee recommends that Resolution 235 be adopted as amended.

(27) RESOLUTION 236 - AMA SUPPORT FOR NUTRITION RESEARCH

RECOMMENDATION A:

Resolution 236 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association seek national legislation in support of the President's FY24 Budgetary request that the additional funding for National Institutes of Health's (NIH's) Office of Nutrition Research (ONR) receive at least \$121,000,000, as this level of funding would to enable ONR to secure the leadership, organizational structure, and resources to effectively fulfill its important mission. (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Resolution 236 be amended by addition of a second Resolve to read as follows:

RESOLVED, That our AMA encourage the NIH to prioritize research with maximal applicability to human health conditions, and that it seek input from physicians and the public regarding research priorities and maintain transparency in its planning processes.

RECOMMENDATION C:

Resolution 236 be adopted as amended.

HOD ACTION: Resolution 236 adopted as amended.

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)

Your Reference Committee heard mostly supportive testimony for Resolution 236. Your Reference Committee heard testimony around the importance of increased funding for nutrition-based research that promotes access to healthy diet and lifestyle choices that prevent disease and overcome systemic health inequities. However, your Reference Committee heard that this resolution needs to be amended so that it is not tied to the President's 2024 budget since it will limit the amount of time that this policy is relevant for. To ensure the policy remains relevant and applicable well into the future, we have recommended amending the language so that the resolution supports general increased funding

levels for nutrition-based research without denoting a particular budgetary cycle. Moreover, testimony noted that the Resolution language should be broadened beyond legislation in recognition that there are several effective ways to advocate for increased funding levels, including for example submitting programmatic requests through the federal appropriations process. Additional testimony noted that nutrition research alone was not enough, and that the research needed to be put into action to truly have the desired impact. As such, this testimony proffered an amendment that our AMA should encourage the NIH to prioritize research with maximal applicability to human health conditions. Therefore, your Reference Committee recommends that Resolution 236 be adopted as amended.

(28) RESOLUTION 244 - RECIDIVISM

RECOMMENDATION A:

The first Resolve of Resolution 244 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate and encourage federal, state, and local legislators and officials to increase access to the number of community mental health facilities, community drug rehabilitation facilities, appropriate clinical care, and social support services (e.g., housing, transportation, employment, etc.) to meet the needs of indigent, homeless, and released previously incarcerated persons (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 244 be deleted.

~~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~~

RECOMMENDATION C:

The third Resolve of Resolution 244 be deleted.

~~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~~

RECOMMENDATION D:

The fourth Resolve of Resolution 244 be deleted.

~~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~~

RECOMMENDATION E:

AMA Policy H-430.986(2) be amended by addition to read as follows:

2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.

RECOMMENDATION F:

Resolution 244 be adopted as amended.

RECOMMENDATION G:

The title of Resolution 218 be changed to read as follows:

IMPROVING CARE TO LOWER THE RATE OF RECIDIVISM

HOD ACTION: Resolution 244 adopted as amended with a change of title.

IMPROVING CARE TO LOWER THE RATE OF 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)

Your Reference Committee heard supportive testimony for the spirit of Resolution 244. Your Reference Committee heard that AMA policies already cover many areas relating to support for ensuring care for mental health and substance use disorder treatment for those in carceral settings. Your Reference Committee, however, heard that this Resolution contains nuances that are not as explicit in current AMA policy. Your Reference Committee heard supportive testimony that our AMA should support access to evidence-based treatment for mental health and substance use disorders upon release from a correctional setting and for those previously incarcerated. Your Reference Committee also heard support for our AMA to promote increased access to housing, rehabilitation facilities, and government or commercial insurance upon release from a correctional setting. Your Reference Committee also heard support from a representative from the Centers for Disease Control and Prevention for referrals to appropriate clinical care and social support services, including but not limited to housing, transportation, and employment. Your Reference

Committee heard that our AMA has multiple, related policies covering most of the resolution, but not all of the nuances. Therefore, your Reference Committee recommends that Resolution 244 be adopted as amended and that existing AMA policy H-430.986 be adopted as amended.

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

(29) RESOLUTION 245 - BIOSIMILAR/ INTERCHANGEABLE
TERMINOLOGY

RECOMMENDATION A:

The first Resolve of Resolution 245 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~rescind~~ repeal policy H-125.976, Biosimilar Interchangeability Pathway (Rescind HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 245 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for continued evidence development pertaining to the interchangeability designation and the necessity for such designation, in state and federal regulations, 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)

RECOMMENDATION C:

Resolution 245 be adopted as amended.

HOD ACTION: Resolution 245 referred.

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)

Your Reference Committee heard mixed testimony for Resolution 245. Testimony stated that our AMA remains concerned about the interpretation and use of the biosimilar-interchangeable terminology. Your Reference Committee also heard that, specifically, the FDA’s use of the term “interchangeability” must be removed from AMA policy and as an FDA designation overall. Testimony noted that our AMA remains concerned with any regulatory actions that draw unnecessary distinctions between biosimilars and their reference products and interfere with physician and patient choice. Furthermore, testimony encouraged further study on the value of the “interchangeability” designation. Your Reference Committee also heard that removing the term “interchangeable” may result in increased costs, and furthermore that other countries do not have this designation as their purpose is already understood. Accordingly, your Reference Committee recommends that Resolution 245 be adopted as amended.

(30) RESOLUTION 259 - STRENGTHENING SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

RECOMMENDATION A:

The first Resolve of Resolution 259 be deleted.

~~RESOLVED, That our AMA support increases and oppose decreases in funding, eligibility, benefit generosity, and purchasing power incentives in the Supplemental Nutrition Assistance Program (SNAP); and be it further~~

RECOMMENDATION B:

The fourth Resolve of Resolution 259 be deleted.

~~RESOLVED, That our AMA actively support elimination of the five-year SNAP waiting period for otherwise qualifying immigrants and expansion of SNAP to otherwise qualifying Deferred Action Childhood Arrivals (DACA) recipients.~~

RESOLVED, That our AMA actively support elimination of the five-year SNAP waiting period for otherwise qualifying immigrants and expansion of SNAP to otherwise qualifying Deferred Action Childhood Arrivals (DACA) recipients.

RECOMMENDATION C:

Resolution 259 be adopted as amended.

RECOMMENDATION D:

AMA Policies 150.937 and 440.927 be reaffirmed.

HOD ACTION: Resolution 259 adopted as amended with an additional Resolve and AMA Policies 150.937 and 440.927 reaffirmed.

RESOLVED, That our AMA advocate for increased federal funding for the Supplemental Nutrition Assistance Program (SNAP) that improves and expands benefits and broadens eligibility.

RESOLVED, That our AMA support increases and oppose decreases in funding, eligibility, benefit generosity, and purchasing power incentives in the Supplemental Nutrition Assistance Program (SNAP); and be it further

RESOLVED, That our AMA support allowing the use of SNAP benefits to purchase hot, heated, and prepared foods at SNAP-eligible vendors; and be it further

RESOLVED, That our AMA support expanding SNAP to U.S. territories that currently receive capped block grants for nutrition assistance; and be it further

RESOLVED, That our AMA actively support elimination of the five-year SNAP waiting period for otherwise qualifying immigrants and expansion of SNAP to otherwise qualifying Deferred Action Childhood Arrivals (DACA) recipients.

Your Reference Committee heard testimony mostly in support of Resolution 259. Your Reference Committee heard that the temporary COVID-era expansions of the Supplemental Nutrition Assistance Program (SNAP) expired earlier this year, resulting in widespread benefit disruption in the face of persistent inflation. Your Reference Committee further heard that SNAP benefits have historically been insufficient and that SNAP's benefit formula was updated in 2021 for the first time in 15 years to better reflect accurate costs of healthy diets. Your Reference Committee also

heard testimony that increased SNAP purchasing power at farm direct outlets is associated with increased spending on fruits and vegetables and higher fruit and vegetable consumption, and that permanently codifying COVID-era expansions that expanded SNAP for purchase of hot, heated, and prepared items at SNAP-eligible vendors would increase healthy options for participants. Your Reference Committee further heard that documented adult immigrants are subject to a five-year SNAP eligibility waiting period, contributing to a lower SNAP participation rate among households with mixed immigration status compared to households with all citizens. Your Reference Committee also heard that the first and fourth resolve clauses are already supported by existing AMA policies H-150.937 and D-440.927 and heard a recommendation that these policies be reaffirmed in lieu of these two resolves. Therefore, your Reference Committee recommends that Resolution 259 be adopted as amended and that existing AMA policies H-150.937 and D-440.927 be reaffirmed.

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927

Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (31) RESOLUTION 214 - ADVOCACY AND ACTION FOR A SUSTAINABLE MEDICAL CARE SYSTEM
RESOLUTION 234 - MEDICARE PHYSICIAN FEE SCHEDULE UPDATES AND GRASSROOTS CAMPAIGN
RESOLUTION 257 - AMA EFFORTS ON MEDICARE PAYMENT REFORM

RECOMMENDATION: Alternate Resolution 214 be adopted in lieu of Resolutions 214, 234, and 257.

AMA EFFORTS ON MEDICARE PAYMENT REFORM

RESOLVED, That our American Medical Association declare Medicare physician payment reform as an urgent advocacy and legislative priority for our AMA; and be it further

RESOLVED, That our AMA prioritize significant increases in funding for federal and state advocacy budgets specifically allocated to achieve Medicare physician

payment reform to ensure that physician payments are updated annually at least equal to the annual percentage increase in the Medicare Economic Index; and be it further

RESOLVED, That our AMA Board of Trustees report back to the House of Delegates at each annual and interim meeting on the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved.

RESOLVED, That AMA Policy D-390.922 be amended by addition and deletion to read as follows:

Physician Payment Reform and Equity, D-390.922

Our AMA will ~~develop~~ implement a comprehensive advocacy campaign, including a sustained national media strategy engaging patients and physicians in promoting Medicare physician payment reform, to achieve enactment of reforms to the Medicare physician payment system consistent with AMA policy and in accord with the principles (Characteristics of a Rational Medicare Payment System) endorsed by over 120 state and medical specialty Federation of Medicine members.

RESOLVED, That our AMA reaffirm AMA Policy H-390-849, “Physician Payment Reform,” which states, among other things, that our AMA will advocate for the development and adoption of physician payment reforms that are designed with input from the physician community, do not require budget neutrality within Medicare Part B, and are based on payment rates that are sufficient to cover the full cost of sustainable medical practice.

RESOLVED, That our AMA reaffirm AMA Policy D-390.946, “Sequestration,” which states, among other things, that our AMA will continue to seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs, ensure Medicare physician payments are sufficient to safeguard beneficiary access to care, and work towards the elimination of budget neutrality requirements within Medicare Part B; as well as our AMA advocate strongly to the Administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

HOD ACTION: Alternate Resolution 214 adopted in lieu of Resolutions 214, 234, and 257.

Resolution 214:

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)

Resolution 234:

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)

Resolution 257:

RESOLVED, That our American Medical Association House of Delegates declare Medicare physician payment reform as both an urgent and a top advocacy and legislative priority for our AMA; and be it further

RESOLVED, That our AMA prioritize significant increases in funding for federal and state advocacy budgets specifically to ensure Medicare physician payment reforms are achieved and updated annually according to the Medicare Economic Index; and be it further

RESOLVED, That our AMA use the increased federal and state advocacy funding to:

1. Create and sustain a national media strategy and campaign promoting Medicare physician payment reform;
2. Fund Washington, D.C., fly-ins, with a white coat march promoting Medicare physician payment reform; and
3. Develop and implement any additional new strategies to accomplish this goal;

And be it further;

RESOLVED, That our AMA consider this policy the top advocacy priority until this goal is accomplished; and be it further

RESOLVED, That the next National Advocacy Conference be sharply focused upon reforming the Medicare payment system to create a more sustainable payment formula for physician practices with annual updates according to the Medicare Economic Index; and be it further

RESOLVED, That our AMA Board of Trustees report back to the house at each annual and interim session on the progress of our AMA staff and physicians until this goal is accomplished.

Your Reference Committee heard unanimous support for the goals of Resolutions, 214, 234, and 257. Your Reference Committee heard testimony expressing intense frustration with the current Medicare physician payment system and its lack of positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs. Testimony stated that the current physician payment system is in crisis and driving private practices out of business. Your Reference Committee heard passionate testimony arguing that achieving permanent physician payment reform should be our AMA's highest advocacy priority and supporting the types of additional actions called for in Resolution 234 and 237, including a significant increase in funding to advocate for physician payment reform, creating a sustained media strategy, and enhancing our AMA's grassroots efforts by engaging patients in our AMA's advocacy efforts. Your Reference Committee also heard testimony that our AMA has already initiated a comprehensive advocacy campaign to achieve enactment of reforms to the Medicare physician payment system consistent with AMA policy and in accord with the principles ([Characteristics of a Rational Medicare Payment System](#)) endorsed by over 120 state and medical specialty Federation of Medicine members. Your Reference Committee heard testimony that our AMA, in collaboration with Federation members, has successfully advocated for the introduction of [H.R. 2474](#), the "Strengthening Medicare for Patients and Providers Act," a bipartisan bill that provides for a payment update that is equal to the annual percentage increase in the Medicare Economic Index ([Federation sign-on support letter](#)), and that our AMA is collaborating with Federation members to secure additional bipartisan cosponsors for this legislation and

to educate Congress on why it is needed, as well as strongly advocating for this bipartisan legislation to be introduced in the Senate. ([Federation sign-on letter](#)). Testimony also highlighted a number of other recently enhanced AMA advocacy activities, including: the relaunching of the [FixMedicareNow.org](#) campaign to build awareness and support through a highly visible paid and earned media tactic, as well as a grassroots and grasstops strategy to position our AMA as a go-to source for information about Medicare payment reform and to establish a strong grassroots base of patients and physicians ready to call on Congress to take action; a patient message testing initiative with patient focus groups and polling that will begin this month; collaboration with Federation members in drafting legislation to reform the budget neutrality policies that have been producing across-the-board payment cuts; and developing several impactful advocacy resources, which can be found [here](#). Your Reference Committee also heard testimony that these AMA advocacy efforts and our AMA's collaboration with Federation members is not being effectively communicated to AMA members in general, or to the media and patients, despite [AMA advocacy updates](#), [press releases](#), and other communication efforts. Your Reference Committee heard testimony in strong agreement that our AMA should improve its communication and outreach, but that the specific strategy and tactics to implement these advocacy efforts have been and should continue to be decided by the Board and senior management. Your Reference Committee acknowledges the intense frustration of those who testified in support of Resolutions, 214, 234, and 257. At the same time, your Reference Committee acknowledges the significant advocacy efforts our AMA has initiated based on recently adopted policy. Your Reference Committee considered an alternate resolution offered during the hearing that captures the essence of these resolutions while leaving the specific strategy and tactics to the Board. Your Reference Committee agrees with this approach and believes the Alternate Resolution should be further strengthened to capture some of the provisions in Resolution 237. In addition, your Reference Committee alternate resolves reflect comments on the importance of enhancing our AMA's visible advocacy on this crucial issue. Therefore, your Reference Committee recommends that Alternate Resolution 214 be adopted in lieu of Resolutions 214, 234, and 257.

Physician Payment Reform H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
 - a) promote improved patient access to high-quality, cost-effective care;
 - b) be designed with input from the physician community;
 - c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
 - d) not require budget neutrality within Medicare Part B;
 - e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
 - f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
 - g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
 - h) use adequate risk adjustment methodologies;
 - i) incorporate incentives large enough to merit additional investments by physicians;
 - j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
 - k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
 - l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
 - m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit 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, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Sequestration D-390.946

Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in MIPS with positive incentive payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

- (32) RESOLUTION 219 - REPEALING THE BAN ON PHYSICIAN-OWNED HOSPITALS
RESOLUTION 222 - PHYSICIAN OWNERSHIP OF HOSPITAL BLOCKED BY THE ACA
RESOLUTION 261 - PHYSICIAN OWNED HOSPITALS

RECOMMENDATION A:

The first Resolve of Resolution 219 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association advocate for policies that remove ~~alleviate any~~ restrictions 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-

RECOMMENDATION B:

The second Resolve of Resolution 219 be deleted.

~~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~~

RECOMMENDATION C:

The third Resolve of Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~encourage further~~ study and research ~~into the benefits and drawbacks~~ impact of the repeal of the ban on physician-owned hospitals on the access to, cost, and quality of, patient care, of physician-owned hospitals and their impact on patient care competition in highly concentrated hospital markets; ~~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

RECOMMENDATION D:

The fourth Resolve of Resolution 219 be deleted.

~~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~~

RECOMMENDATION E:

The seventh Resolve of Resolution 219 be amended by addition and deletion to read as follows:

~~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.~~

RECOMMENDATION F:

The eighth Resolve of Resolution 219 be deleted.

~~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)~~

RECOMMENDATION G:

Resolution 219 be adopted as amended in lieu of Resolutions 222 and 261.

RECOMMENDATION H:

The title of Resolution 219 be changed to read as follows:

PHYSICIAN-OWNED HOSPITALS

HOD ACTION: Resolution 219 adopted as amended in lieu of Resolutions 222 and 261 with a change of title.

PHYSICIAN-OWNED HOSPITALS

Resolution 219:

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)

Resolution 222:

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)

Resolution 261:

RESOLVED, That our American Medical Association study the patient selection practices of both physician-owned and non-physician-owned hospitals to better understand the impact of hospital ownership status on access to care through:

1. A thorough review of the existing literature;
2. Analyzing patient characteristics across both physician-owned and non-physician-owned hospitals to elucidate whether there are any meaningful differences between these 2 populations. This study should take into account that half of physician-owned hospitals are community hospitals and half are specialty hospitals focused on cardiac, orthopedic, or surgical care;
3. Proposing solutions if there are meaningful differences in these patient populations to ensure equitable access to care (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association conduct a comprehensive study into the impact of Section 1877 of the Social Security Act, the Physician Self-Referral Law (also called the Stark Law), on physician-owned hospitals and market-wide consolidation, including the following:

1. Analyzing the impact that restrictions on physician-owned hospitals enacted by the Stark Law have had on patient access to care, in terms of both cost and quality;
2. Examining the impact of the Stark Law on physician practices, especially those that are integrated or affiliated with physician-owned hospitals;
3. Understanding the extent to which the Stark Law has driven market consolidation and, in doing so, impacted healthcare costs, quality, and patient access to care;
4. Proposing alternative approaches to the Stark Law, including consideration of repeal of relevant provisions, that would promote competition and improve patient access to high-quality care (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association study the impact of Section 6001 of the Patient Protection and Affordable Care Act on physician hospital ownership metrics, physician fiscal health and retirement, physician

burnout, patient continuity of care, physician turnover within hospitals, and most importantly physicians' empowerment to advocate for the health and wellbeing of their patients (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association report the initial findings of studies into Section 1877 of the Social Security Act and/or Section 6001 of the Patient Protection and Affordable Care Act to the House of Delegates by Annual 2024 (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of the repeal of the ban on physician-owned hospitals on patients, physicians, and hospital prices. (Directive to Take Action)

Your Reference Committee heard mixed testimony concerning Resolutions 219, 222, and 261. Testimony urged that our AMA provide additional advocacy support for physician-owned hospitals. Your Reference Committee heard that advocacy surrounding physician-owned hospitals is ultimately in the best interest of patients. Your Reference Committee heard that our AMA should continue to educate AMA members and the public on the potential benefits of physician ownership of hospitals and the need for policies that support such ownership. Your Reference Committee also heard that Resolutions 219, 222, and 261 were very similar. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended in lieu of Resolutions 222 and 261.

- (33) RESOLUTION 237 - PROHIBITING COVENANTS NOT-TO-COMPETE IN PHYSICIAN CONTRACTS
RESOLUTION 263 - ELIMINATION OF NON-COMPETE CLAUSES IN EMPLOYMENT CONTRACTS

RECOMMENDATION:

Resolution 237 be adopted in lieu of Resolution 263.

HOD ACTION: Resolution 237 adopted in lieu of Resolution 263.

Resolution 237:

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)

Resolution 263:

RESOLVED, That our AMA support the elimination of restrictive not-to-compete clauses within contracts for all physicians in clinical practice, regardless of the for-profit or not-for-profit status of the employer; and be it further

RESOLVED, That our AMA strongly advocate for policies that enable all physicians, including residents and fellows currently in training, to have greater professional mobility and the ability to serve multiple hospitals, thereby increasing specialist coverage in communities and improving overall patient care; and be it further

RESOLVED, That our AMA ask the Council on Ethical and Judicial Affairs to evaluate amending the AMA Code of Medical Ethics in order to oppose non-compete clauses.

Your Reference Committee received diverse testimony concerning Resolutions 237 and 263. The testimony heavily favored Resolution 237 as opposed to Resolution 263. Your Reference Committee heard that Resolution 237, which in its first Resolved calls on our AMA to oppose the use of noncompetes in physician employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers, received wide-spread support. However, testimony did not support Resolution 263. Your Reference Committee heard that Resolution 263 was opposed because the first resolve clause of Resolution 263 calls on our AMA to oppose the use of physician noncompetes with any employer, which would include independent physician practices. Testimony expressed concern that prohibiting independent physician practices from using noncompetes would harm competition and weaken independent practices' because they would not be able to use reasonable noncompetes to protect the investments they make in their physicians. Your Reference Committee did not receive any testimony opposing the adoption of the second resolve clause of Resolution 237, although your Reference Committee notes that the second resolve clause of Resolution 237 is already covered by AMA Code of Ethics Opinion 11.2.3.1 Restrictive Covenants. Finally, your Reference Committee received broad support for the study called for by the third resolve clause of Resolution 237 and no opposition was expressed. Therefore, your Reference Committee recommends that Resolution 237 be adopted in lieu of 263.

- (34) RESOLUTION 239 - CREATING AN AMA TASKFORCE DEDICATED TO THE ALIGNMENT OF SPECIALTY
RESOLUTION 262 - ALIGNMENT OF SPECIALTY DESIGNATIONS FOR ADVANCED PRACTICE PROVIDERS WITH THEIR SUPERVISING PHYSICIANS

RECOMMENDATION A:

The first Resolve of Resolution 239 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association Board of Trustees study and report back at the 2023 Interim meeting on the movement of nonphysician health care professionals, such as physician assistants and nurse practitioners, economic impact to between and other lower tier income medical specialties of specialties switching by Advanced Practice Providers (Directive to Take Action), and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 239 be deleted.

~~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)~~

RECOMMENDATION C:

Resolution 239 be adopted as amended in lieu of Resolution 262.

RECOMMENDATION D:

The title of Resolution 239 be changed to read as follows:

**PHYSICIAN ASSISTANT AND NURSE PRACTITIONER MOVEMENT
BETWEEN SPECIALTIES**

**HOD ACTION: Resolution 239 adopted as amended in lieu of Resolution 262
with a change of title.**

**PHYSICIAN ASSISTANT AND NURSE PRACTITIONER MOVEMENT
BETWEEN SPECIALTIES**

Resolution 239:

RESOLVED, That our American Medical Association create a national task force that will make recommendations for the best process for advanced practice providers (APPs) to develop specialty designations or an associated apprenticeship process that is parallel to the specialties of the physicians that supervise them (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association study and report back at Interim 2023 on the economic impact to medical practices of specialty switching by advanced practice providers (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association study and report back at the 2023 Interim Meeting about possible options on how advanced practice providers can best be obligated to stay in a specialty tract (Directive to Take Action).

Resolution 262:

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)

Your Reference Committee heard limited testimony on Resolution 239 and Resolution 262. Your Reference Committee heard that the first resolve clause of Resolution 262 is being addressed by CME Report 9 (A-23) and notes that our AMA does not have the authority or purview over post-graduate clinical training requirements of nonphysicians. Your Reference Committee heard that our AMA has extensive resources on the education and training of nonphysicians, including information confirming, for example, that the majority of nurse practitioners are educated, trained, and certified in primary care. Yet, research suggests that a growing number of non-physician practitioners are moving between specialties. Your Reference Committee heard personal observations that this rings true. Your Reference Committee heard concern regarding the tone and specificity of Resolutions 239 and 262, particularly on the limited focus of primary care, as well as the inappropriate role of our AMA setting up “functional barriers” as described in Resolution 239. Your Reference Committee also heard that there is a need to act on this issue. Your Reference Committee received an amendment which sought to meet the underlying concern raised in Resolutions 239 and 262 while also directing our AMA to act by studying the root cause of the issue. Therefore, your Reference Committee recommends that Resolution 239 be adopted as amended in lieu of Resolution 262.

- (35) RESOLUTION 247 - ASSESSING THE POTENTIALLY DANGEROUS INTERSECTION BETWEEN AI AND MISINFORMATION
 RESOLUTION 251 - FEDERAL GOVERNMENT OVERSIGHT OF AUGMENTED INTELLIGENCE
 RESOLUTION 256 - REGULATING MISLEADING AI GENERATED ADVICE TO PATIENTS

RECOMMENDATION:

Alternate Resolution 247 be adopted in lieu of Resolutions 247, 251, and 256.

Assessing the Intersection Between Augmented Intelligence (AI) and Healthcare

RESOLVED, That our American Medical Association study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24 (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the federal government 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 LLMs including GPTs. (New HOD Policy)

RESOLVED, Our AMA support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence.

HOD ACTION: Alternate Resolution 247 adopted as amended in lieu of Resolutions 247, 251, and 256.

Resolution 247:

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 report back at the 2023 Annual meeting. (Directive to Take Action)

Resolution 251:

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)

Resolution 256:

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)

Your Reference Committee heard sparse but supportive testimony for the spirit of Resolutions 247, 251, and 256. Testimony noted the similarity of the requests contained in Resolutions 247, 251, and 256 and accordingly offered an alternative resolution that covers the spirit of all of the Resolutions. Your Reference Committee heard testimony in support of Alternate Resolution 247. Your Reference Committee heard testimony that our AMA remains concerned about the ability and the abundance of generated medical advice that is being produced via platforms such as ChatGPT and other large language models. Your Reference Committee also heard that, while existing AMA policy on this topic is vast, recommendations proffered by the combined resolution supports the need for the creation of updated policy that is sensitive to the need for educational support for physicians on the impacts of newer generative augmented intelligence (AI) tools that may influence clinical decision making. Your Reference Committee also heard testimony that encouraged advocacy on the creation of guardrails and the threat that AI may have that could resemble the spread of misinformation that social media has evidenced. Your Reference Committee heard testimony that if the potential threats are not addressed, the risk of misinformation spread by AI may make physicians' jobs harder or potentially impossible. Your Reference Committee heard testimony that no current policy exists on this topic. Accordingly, your Reference Committee recommends adopting Alternate Resolution 247 in lieu of Resolutions 247, 251, and 256.

RECOMMENDED FOR REFERRAL

(36) RESOLUTION 202 - SUPPORT FOR MENTAL HEALTH COURTS

RECOMMENDATION:

Resolution 202 be referred.

HOD ACTION: Resolution 202 referred.

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)

Your Reference Committee heard mixed testimony on Resolution 202. Testimony expressed support for evidence-based treatment for those with a mental illness, substance use disorder, or other medical disease. Testimony noted support for our current AMA policy concerning "drug courts." However, your Reference Committee heard considerable testimony raising substantive concerns about "mental health courts," including uncertainty about whether Resolution 202 would lead to unintentional, adverse consequences for those with a mental illness. Your Reference

Committee also heard testimony stating concern that increased support for “mental health courts” could lead to increased use of involuntary commitment or increased disparities in care. Testimony noted that some states and local jurisdictions might use different terminology to describe mental health courts or drug courts. Your Reference Committee did not hear testimony, however, about best practices of mental health courts, drug courts, sobriety courts or other similarly named entities. Based upon the diversity of testimony your Reference Committee acknowledges that more information concerning the background and criteria of mental health courts and the difference between drug courts and mental health courts and the uses of each is needed. Your Reference Committee, therefore, recommends that Resolution 202 be referred.

(37) RESOLUTION 203 – DRUG POLICY REFORM

RECOMMENDATION:

Resolution 203 be referred.

HOD ACTION: Resolution 203 referred.

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)

Your Reference Committee heard conflicting testimony on Resolution 203. Testimony noted that the issue of decriminalization of the possession of illicit substances for personal use/possession is one that our AMA has no policy on and as such, it is one of first impression for our AMA. Your Reference Committee heard testimony that noted concerns that this Resolution seeks to wholesale replace the current regulatory structure governing possession of illicit substances without making any suggestions for replacing it. Your Reference Committee also heard testimony that the so-called “War on Drugs” has not led to reductions in drug-related mortality or meaningful increases in treatment for those with a substance use disorder. Your Reference Committee also heard testimony about how the current regulatory structure governing drug possession is inequitable for Brown and Black Americans. Your Reference Committee is concerned, however, that the testimony provided insufficient evidence to argue in favor of removing the current regulatory structure and decriminalizing illicit drug possession offenses, have them expunged, or remove certain penalties. Your Reference Committee heard overwhelming testimony concerning the need for additional information so that the unintended consequences of the potential adoption of Resolution 203 can be understood. Your Reference Committee, therefore, recommends that Resolution 203 be referred.

(38) RESOLUTION 204 - SUPPORTING HARM REDUCTION

RECOMMENDATION:

Resolution 204 be referred.

HOD ACTION: Resolution 204 referred.

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)

Your Reference Committee heard mixed testimony on Resolution 204. Testimony stated that more must be done to increase access to buprenorphine to treat opioid use disorders (OUD). Compelling testimony stated that buprenorphine is not a “harm reduction” tool so much as it is part of treatment for OUD. Your Reference Committee heard testimony that the use of non-prescribed buprenorphine presents a low risk, but there is a difference between anecdotal evidence and deliberative review of available research. Your Reference Committee notes that it heard strong and consistent testimony in opposition to our AMA supporting “safer smoking.” Your Reference Committee also heard conflicting testimony concerning the use of non-prescribed buprenorphine, including that there is an absence of current AMA policy to guide our AMA with respect to decriminalization of a Schedule III Controlled Substance. Your Reference Committee, therefore, recommends that Resolution 204 be referred.

- (39) RESOLUTION 240 - ATTORNEYS’ RETENTION OF CONFIDENTIAL MEDICAL RECORDS AND CONTROLLED MEDICAL EXPERT’S TAX RETURNS AFTER CASE ADJUDICATION

RECOMMENDATION:

Resolution 240 be referred.

HOD ACTION: Resolution 240 referred.

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)

Your Reference Committee received little testimony regarding Resolution 240. No opposition to Resolution 240 was expressed. However, testimony indicated that Resolution 240 raises complex issues that need to be studied further and a greater understanding needs to be obtained about the potential consequences of adopting Resolution 240. Accordingly, your Reference Committee recommends that Resolution 240 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

- (40) RESOLUTION 258 - ADJUSTMENTS TO HOSPICE DEMENTIA ENROLLMENT CRITERIA

RECOMMENDATION:

Resolution 258 by referred for decision.

HOD ACTION: Resolution 258 referred for decision.

RESOLVED, That the American Medical Association actively lobby the Centers for Medicare & Medicaid Services (CMS) to adjust the secondary hospice enrollment criteria for dementia. Specifically, CMS should incorporate dementia patients who are Functional Assessment Staging Test Stage 6e, who, or their families on their behalf, have chosen not to receive medications or interventions for acute illnesses.

Your Reference Committee heard limited testimony on Resolution 258. Your Reference Committee heard that the existing admission criteria for hospice enrollment for dementia patients relies on the Functional Assessment Staging Test (FAST) scoring mechanism, which measures activities of daily living and rates appetite, nourishment, and mobility, based on the presumption of a linear progression (ordinal) of decline. Your Reference Committee further heard that the FAST scoring criteria do not accurately predict survival rates for dementia patients (or their families on their behalf) who have chosen not to receive medications or interventions for acute illnesses, and that the scoring criteria for secondary hospice enrollment needs to be changed. Your Reference Committee heard testimony in support of an amendment to clarify the requests in the Resolution. However, your Reference Committee also heard that there was not enough background or evidence provided by the authors to support adoption: while statistics are provided in the whereas clauses of the Resolution, there are no citations or sources for such statistics, and therefore it is difficult to ascertain whether this ask is something our AMA should “actively lobby” the Centers for Medicare and Medicaid Services to adopt. Your Reference Committee heard testimony that given the lack of information and understanding surrounding this Resolution that it should be referred to the Board for decision. The author of the Resolution said that they would accept referral for decision. Therefore, your Reference Committee recommends that Resolution 258 be referred for decision.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

- (41) RESOLUTION 205 - AMENDING H-160.903, ERADICATING HOMELESSNESS, TO REDUCE EVICTIONS AND PREVENT HOMELESSNESS

RECOMMENDATION:

AMA Policy H-160.903 be reaffirmed in lieu of Resolution 205.

HOD ACTION: AMA Policy H-160.903 reaffirmed in lieu of Resolution 205.

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)

Your Reference Committee heard mixed testimony about Resolution 205. Your Reference Committee heard passionate testimony expressing concerns about homelessness, and that affordable housing is important and social needs such as housing, or the lack of housing, have a profound impact on health outcomes. Your Reference Committee also heard that after hospitals for patients experiencing mental illness closed, community/group home alternatives did not materialize to meet housing needs. Testimony also noted that creative solutions to the homelessness crisis include rent-control laws, just eviction statutes, right to counsel policies, and the creation of local, state, and/or national rental registries to monitor tenant and landlord contracts and prevent unlawful evictions. However, your Reference Committee further heard that this Resolution calls for our AMA to support specific mechanisms and policies to achieve affordable housing, and our AMA does not have expertise in housing policy or landlord/tenant law. Your Reference Committee heard that as a result, our AMA does not know whether these are the right policies or what their unintended consequences may be. Your Reference Committee also heard concerns expressed about the unintended consequences of rent control laws with regard to price controls. Your Reference Committee further heard that existing AMA policy H-160.903, on eradicating homelessness, already 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. Moreover, your Reference Committee heard that this policy also recognizes more broadly that 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. Your Reference Committee heard that this policy should be reaffirmed in lieu of adoption. Accordingly, your Reference Committee recommends that existing AMA policy H-160.903 be reaffirmed in lieu of Resolution 205.

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.
- (42) RESOLUTION 210 - THE HEALTH CARE RELATED EFFECTS OF RECENT CHANGES TO THE US MEXICO BORDER

RECOMMENDATION:

That AMA Policies D-350.975, D-160.988, D-65.992, and D-255.980 be reaffirmed in lieu of Resolution 210.

HOD ACTION: AMA Policies D-350.975, D-160.988, D-65.992, and D-255.980 reaffirmed in lieu of Resolution 210.

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)

Your Reference Committee heard mixed that was passionate on both sides of this issue for Resolution 210. In general, your Reference Committee heard that our AMA has a strong immigration policy platform that includes policies on health care at the border, immigrant privacy, immigrant access to public services, and physician payment for care of immigrants regardless of immigration status. Testimony noted that our AMA has been able to advocate to the Administration and Congress via detailed comment letters on immigrant health at the border and in detention centers. In addition, our AMA has advocated on the changes to the legal process for asylum seekers, the legal review standard for immigrants attempting to immigrate by crossing the border and more. As such, testimony stated that reaffirmation of current AMA policy would be more appropriate. Furthermore, testimony highlighted that Resolution 210 would not help to build upon existing AMA policy. Instead, Resolution 210 would make our AMA appear out of touch since the physical size of the border wall is not an important immigration issue under this Administration. Moreover, testimony highlighted that our AMA already has policy that supports harm reduction for immigrants. Your Reference Committee also heard that our AMA's advocacy resources have been directed to providing timely comments, advice, opposition, and support for issues regarding immigrant health at the border and within the nation as a whole under current AMA policy. Therefore, your Reference Committee recommends that existing AMA policies D-350.975, D-160.988, D-65.992, and D-255.980 be reaffirmed in lieu of Resolution 210.

Immigration Status is a Public Health Issue D-350.975

1. Our AMA declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

Financial Impact of Immigration on American Health System D-160.988

Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid.

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992

1. Our AMA will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.
2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.
3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.
4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of: (A) the health needs of this unique population, including standard pediatric care as well as mental health needs; (B) health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals; (C) the resources required to address these needs, including but not limited to monetary resources, medical care

facilities and equipment, and pharmaceuticals; and (D) avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

(43) RESOLUTION 212 - MARIJUANA PRODUCT SAFETY

RECOMMENDATION:

That AMA Policies D-95.969, H-95.952, H-95.924, and H-95.936 be reaffirmed in lieu of Resolution 212.

HOD ACTION: AMA Policies D-95.969, H-95.952, H-95.924, and H-95.936 reaffirmed in lieu of Resolution 212.

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)

Your Reference Committee heard mixed testimony on Resolution 212. Testimony stated that cannabis use presents challenging issues for physicians and patients. Testimony noted that cannabis for medical use as well as adult (also referred to as “recreational”) use is legal in many states. Your Reference Committee heard that state regulation of cannabis for medical and/or adult use is viewed differently by different states. Your Reference Committee heard that States would like to receive advocacy assistance on this issue. Your Reference Committee encourages our medical society colleagues to work with our AMA Advocacy Resource Center which has resources available for states to advocate for legislative or regulatory changes. Testimony also noted that our AMA has extensive and robust policy on marijuana. Testimony noted policy H-95.924 which testimony stated goes beyond the intent of the second resolve in calling on states “to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth.” Your Reference Committee heard that our AMA has consistently promoted these policies to our state and specialty medical society partners and that more policy is not needed when existing policy already guides our AMA in a clear manner. Your Reference

Committee, therefore, recommends that D-95.969, H-95.952, H-95.924, and H-95.936 be reaffirmed in lieu of Resolution 212.

Cannabis Legalization for Medicinal Use D-95.969

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

Cannabis and Cannabinoid Research H-95.952

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes

states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936

Our AMA advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed.

- (44) RESOLUTION 215 - SUPPORTING LEGISLATIVE AND REGULATORY EFFORTS AGAINST FERTILITY FRAUD

RECOMMENDATION:

That AMA Policies H-140.900 and B-1.1.1 be reaffirmed in lieu of Resolution 215.

HOD ACTION: AMA Policies H-140.900 and B-1.1.1 reaffirmed in lieu of Resolution 215.

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)

Your Reference Committee heard strong testimony in favor of the intent behind Resolution 215 but somewhat mixed testimony in terms of adoption. Your Reference Committee heard that over the past several years, more than 50 fertility doctors in the United States have been accused of illicit insemination by a patient's physician without informed consent, also referred to as fertility fraud. Your Reference Committee also heard strong agreement about the egregious nature of fertility fraud, that it is a violation of our AMA's Code of Medical Ethics, that informed consent does not exist in situations where fertility fraud occurs, as it is illegal. Moreover, testimony stated that this is an issue that should not be legislated since it is illegal and against medical ethics. Your Reference Committee further heard that existing AMA policy could be reaffirmed in lieu of this Resolution since it already covers the intent of this Resolution. Therefore, your Reference Committee recommends that existing AMA policies H-140.900 and B-1.1.1 be reaffirmed in lieu of Resolution 215.

A Declaration of Professional Responsibility H-140.900

Our AMA adopts the Declaration of Professional Responsibility

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY**Preamble**

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

- (1) Respect human life and the dignity of every individual.
 - (2) Refrain from supporting or committing crimes against humanity and condemn any such acts.
 - (3) Treat the sick and injured with competence and compassion and without prejudice.
 - (4) Apply our knowledge and skills when needed, though doing so may put us at risk.
 - (5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
 - (6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
 - (7) Educate the public and polity about present and future threats to the health of humanity.
 - (8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
 - (9) Teach and mentor those who follow us for they are the future of our caring profession.
- We make these promises solemnly, freely, and upon our personal and professional honor.

Active Membership. B-1.1.1

1.1.1.1 Active Constituent. Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States of America. Active constituent members are members of constituent associations who are entitled to exercise the rights of membership in their constituent associations, including the right to vote and hold office, as determined by their respective constituent associations and who meet one of the following requirements:

- a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.
- b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

1.1.1.1.1 Admission. Active constituent members are admitted to membership upon certification by the constituent association to the AMA, provided there is no disapproval by the Council on Ethical and Judicial Affairs.

1.1.1.2 Active Direct. Active direct members are those who apply for membership in the AMA directly. Applicants residing in states where the constituent association requires all of its members to be members of the AMA are not eligible for this category of membership unless the applicant is serving full time in the Federal Services that have been granted representation in the House of Delegates. Active direct members must meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.

b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

1.1.1.2.1 Admission. Active direct members are admitted to membership upon application to the AMA, provided that there is no disapproval by the Council on Ethical and Judicial Affairs.

1.1.1.2.1.1 Notice. The AMA shall notify each constituent association of the name and address of those applicants for active direct membership residing within its jurisdiction.

1.1.1.2.1.2 Objections. Objections to applicants for active direct membership must be received by the Executive Vice President of the AMA within 45 days of receipt by the constituent association of the notice of the application for such membership. All objections will immediately be referred to the Council on Ethical and Judicial Affairs for prompt disposition pursuant to the rules of the Council on Ethical and Judicial Affairs.

1.1.1.3 Council on Ethical and Judicial Affairs Review. The Council on Ethical and Judicial Affairs may consider information pertaining to the character, ethics, professional status and professional activities of the applicant for membership. The Council shall provide by rule for an appropriate hearing procedure to be provided to the applicant.

1.1.1.4 Rights and Privileges. Active members are entitled to receive the Journal of the American Medical Association and such other publications as the Board of Trustees may authorize.

1.1.1.5 Dues and Assessments. Active members are liable for such dues and assessments as are determined and fixed by the House of Delegates.

1.1.1.5.1 Active Constituent Members. Active constituent members shall pay their annual dues to the constituent associations for transmittal to the AMA, except as may be otherwise arranged by the Board of Trustees.

1.1.1.5.2 Active Direct Members. Active direct members shall pay their annual dues directly to the AMA.

1.1.1.5.3 Exemptions. On request, active members may be exempt from the payment of dues on January 1 following their sixty-fifth birthday, provided they are fully retired from the practice of medicine. Additionally, the Board of Trustees may exempt members from payment of dues to alleviate financial hardship or because of retirement from medical practice due to medical disability. The Board of Trustees shall establish appropriate standards and procedures for granting all dues exemptions. Members who were exempt from payment of dues based on age and retirement under Bylaw provisions applicable in prior years shall be entitled to maintain their dues-exempt status in all subsequent years. Dues exemptions for financial hardship or medical disability shall be reviewed annually.

1.1.1.5.4 Delinquency. Active members are delinquent if their dues and assessments are not received by the date determined by the House of Delegates, and shall forfeit their membership in the AMA if such delinquent dues and assessments are not received by the AMA within 30 days after a notification to the delinquent member has been made on or following the delinquency date.

- (45) RESOLUTION 231 - EQUITABLE INTERPRETER SERVICES AND FAIR REIMBURSEMENT

RECOMMENDATION:

That AMA Policies D-385.957, D-385.946, H-160.924, H-385.928, and H-385.917 be reaffirmed in lieu of Resolution 231.

HOD ACTION: AMA Policies D-385.957, D-385.946, H-160.924, H-385.928, and H-385.917 reaffirmed in lieu of Resolution 231.

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)

Your Reference Committee heard mostly supportive testimony for the spirit of Resolution 231. Your Reference Committee heard that the Resolution aligns with our AMA's ongoing efforts to ensure that physicians and healthcare providers are adequately supported in providing high-quality care to all patients, regardless of language barriers. Testimony strongly highlighted that our AMA already has longstanding and substantial policies in place that directly address the concerns raised in the Resolution. Your Reference Committee heard that these existing policies demonstrate our AMA's commitment to advocating for equitable access to healthcare for individuals with limited English proficiency, hearing impairments, and vision impaired as well as fair payment for interpreter services. Your Reference Committee heard that our AMA has written multiple advocacy letters to the Administration on this topic in the past year and is actively engaging to ensure that access is available while at the same time ensuring that physicians are either paid or that physicians do not have to pay for interpreter services. Your Reference Committee heard that while our AMA would not advocate for a new CPT code due to budget neutrality concerns, it strongly supports fair and adequate payment for interpreter services to ensure equitable access to healthcare. Moreover, your Reference Committee acknowledges that American Sign Language is included within the purview of language interpreter services and heard that our AMA already has policy that directly covers payment for sign language interpreters, namely D-385.946. Therefore, your Reference Committee recommends that existing AMA policies D-385.957, D-385.946, H-160.924, H-385.928, and H-385.917 be reaffirmed in lieu of Resolution 231.

Certified Translation and Interpreter Services D-385.957

Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

Physician Reimbursement for Interpreter Services D-385.946

1. Our AMA will prioritize physician reimbursement for interpreter services, including American Sign Language, and advocate for legislative and/or regulatory changes to federal health care programs such as Medicare, Medicare Advantage plans, Tricare, Veterans Administration, etc., for payment for such services.

2. Our AMA will continue to work with interested state and specialty societies to advocate for physician reimbursement for interpreter services, including American Sign Language, for commercial health plans, workers' compensation plans, Medicaid, Medicaid managed care plans, etc., for payment for such services.

Interpreters in the Context of the Patient-Physician Relationship H-160.924

1. AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care; and (d) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

Patient Interpreters H-385.928

Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government.

Interpreter Services and Payment Responsibilities H-385.917

Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.

- (46) RESOLUTION 260 - ADVOCATE TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND THE JOINT COMMISSION TO REDEFINE THE TERM "PROVIDER" AND NOT DELETE THE TERM "LICENSED INDEPENDENT PRACTITIONER"

RECOMMENDATION:

That AMA Policies H-405.968 and H-405.951 be reaffirmed in lieu of Resolution 260.

HOD ACTION: AMA Policies H-405.968 and H-405.951 reaffirmed in lieu of Resolution 260.

RESOLVED, That our American Medical Association request a meeting with the Center for Medicare and Medicaid services (CMS), and The Joint Commission to discuss the definition of terms used in CMS Conditions of Participation, and in TJC Standards (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association advocate that in state and federal rules and regulations and legislation that the use the term "providers" not be used to refer to "physicians" as consistent with AMA policy H-405.968 (Directive to Take Action); and be it further,

RESOLVED, that our American Medical Association encourage the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission not to delete the term and definition of "licensed independent practitioner" (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 260. Testimony was given about the importance of maintaining the term physician and ensuring it is only used to refer to those who are Doctors of Medicine, Doctors of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency. Additional testimony agreed with this position but noted that our AMA already has policy on point and that our AMA already does advocacy in this space. Significant testimony was provided that noted the extensive work that our AMA already does in this space to ensure that physicians are differentiated from providers. Therefore, your Reference Committee recommends that existing AMA policies H-405.968 and H-405.951 be reaffirmed in lieu of Resolution 260.

Clarification of the Term "Provider" in Advertising, Contracts and Other Communications H-405.968

1. Our AMA supports requiring that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform.
2. Our AMA: (a) considers the generic terms "health care providers" or "providers" as inadequate to describe the extensive education and qualifications of physicians licensed to practice medicine in all its branches; (b) will institute an editorial policy prohibiting the use of the term "provider" in lieu of "physician" or other health professionals for all AMA publications not otherwise covered by the existing JAMA Editorial Governance Plan, which protects editorial independence of the Editor in Chief of JAMA and The JAMA Network journals; and (c) will forward to the editorial board of JAMA the recommendation that the term "physician" be used in lieu of "provider" when referring to MDs and DOs.

Definition and Use of the Term Physician H-405.951

Our AMA:

1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
 - a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician;
 - b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and
 - c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA.
7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign

REPORT OF REFERENCE COMMITTEE C

Your Reference Committee recommends the following consent calendar for acceptance:

1. RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 1 – Council on Medical Education Sunset Review of 2013 House of Delegates’ Policies
2. Council on Medical Education Report 3 – Financial Burdens and Exam Fees for International Medical Graduates (Resolution 305-A-22)
3. Council on Medical Education Report 4 – Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance (Resolution 309-A-22, Resolve 2)
4. Council on Medical Education Report 5 – Support for Institutional Policies for Personal Days for Undergraduate Medical Students (Resolution 314-A-22)
5. Council on Medical Education Report 6 – Modifying Financial Assistance Eligibility Criteria for Medical School Applicants
6. Council on Medical Education Report 8 – Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict
7. Council on Medical Education Report 9 – The Impact of Midlevel Providers on Medical Education (Resolution 201-A-22)
8. Resolution 320 – Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession

RECOMMENDED FOR ADOPTION WITH A TITLE CHANGE

9. Resolution 302 – Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and Other Relevant Associations or Organizations

RECOMMENDED FOR ADOPTION AS AMENDED

10. Council on Medical Education Report 2 – Financing Medical Education (Resolution 306-A-22)
11. Resolution 304 – Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement
12. Resolution 305 – Indian Health Service Graduate Medical Education
13. Resolution 306 – Increased Education and Access to Fertility Resources for U.S. Medical Students
14. Resolution 307 – 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
15. Resolution 311 – Residency Application Support for Students of Low-Income Backgrounds
16. Resolution 314 – Support for International Medical Graduates from Turkey

17. Resolution 316 – Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges
18. Resolution 319 – Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement
19. Resolution 321 – Corporate Compliance Consolidation
20. Resolution 322 – Disclosure of Compliance issues and Creating a National Database of Joint Leadership
21. Resolution 323 – Amend Policy D-275.948, “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training”

RECOMMENDED FOR ADOPTION IN LIEU OF

22. Council on Medical Education Report 7 – Management and Leadership Training in Medical Education

Resolution 318 – Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions
23. Resolution 301 – Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education

Resolution 310 – Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation
24. Resolution 308 – Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants
25. Resolution 309 – Against Legacy Preferences as a Factor in Medical School Admissions
26. Resolution 312 – Indian Health Service Licensing Exemptions
27. Resolution 313 – Filtering International Medical Graduates During Residency or Fellowship Applications

Resolution 315 – Prohibit Discriminatory ERAS® Filters In NRMP Match

RECOMMENDED FOR REFERRAL FOR DECISION

28. Resolution 303 – Medical School Management of Unmatched Medical Students

RECOMMENDED FOR ADOPTION

- (1) COUNCIL ON MEDICAL EDUCATION REPORT 1 – COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2013 HOUSE OF DELEGATES' POLICIES

RECOMMENDATION:

Recommendations in Council on Medical Education Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 1 adopted and the remainder of the report filed.

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)

No testimony was received for this report. Your Reference Committee appreciates the Council's efforts to identify policies for sunset and recommends that Council Report 1 be adopted.

- (2) COUNCIL ON MEDICAL EDUCATION REPORT 3 – FINANCIAL BURDENS AND EXAM FEES FOR INTERNATIONAL MEDICAL GRADUATES (RESOLUTION 305-A-22)

RECOMMENDATION:

Recommendations in Council on Medical Education Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 3 adopted and the remainder of the report filed.

1. Our American Medical Association encourages 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.

2. Our AMA encourages relevant stakeholders to work together to achieve cost equivalency for exams required of all medical students and trainees, including IMGs.

3. That AMA policy H-255.988, "AMA Principles on International Medical Graduates," be reaffirmed. (Reaffirm HOD Policy)

CME 3-A-23 received online and live testimony in support of this report. The Federation of State Medical Boards (FSMB) testified that the National Board of Medical Examiners makes no distinction between U.S. MD and DO medical school graduates and international medical graduates, and that the core fees and cost for the United States Medical Licensure Exam (USMLE) transcript are the same for both. The FSMB did acknowledge there were additional costs for processing USMLE transcripts for those who took the exam outside of the United States. The Educational Commission for Foreign Medical Graduates (ECFMG) testified that, despite inflation, fees were held flat for services, and they will propose to not increase fees in 2024. Your Reference Committee recommends that Council Report 3 be adopted.

- (3) COUNCIL ON MEDICAL EDUCATION REPORT 4 – DECREASING BIAS IN ASSESSMENTS OF MEDICAL STUDENT CLINICAL CLERKSHIP PERFORMANCE (RESOLUTION 309-A-22, RESOLVE 2)

RECOMMENDATION:

Recommendations in Council on Medical Education Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 4 adopted and the remainder of the report 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.”

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.

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.

4. Encourage UME institutions to include grading system methodology with grades shared with residency programs.

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”

CME 4-A-23 received online and live testimony in support of this report. Your Reference Committee recommends that Council Report 4 be adopted.

- (4) COUNCIL ON MEDICAL EDUCATION REPORT 5 – SUPPORT FOR INSTITUTIONAL POLICIES FOR PERSONAL DAYS FOR UNDERGRADUATE MEDICAL STUDENTS (RESOLUTION 314-A-22)

RECOMMENDATION:

Recommendations in Council on Medical Education Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 5 adopted and the remainder of the report filed.

Our American Medical Association supports 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.

CME 5-A-23 received online and live testimony in support of this report. Your Reference Committee recommends that Council Report 5 be adopted.

- (5) COUNCIL ON MEDICAL EDUCATION REPORT 6 – MODIFYING FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA FOR MEDICAL SCHOOL APPLICANTS

RECOMMENDATION:

Recommendations in Council on Medical Education Report 6 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 6 adopted and the remainder of the report filed.

1. That AMA policy [D-305.950](#), Modifying Financial Assistance Eligibility Criteria for Medical School Applicants, be amended by addition and deletion to read as follows:

1. Our AMA will encourage the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine to study process reforms to mitigate the high cost of applying to medical school 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).

CME 6-A-23 received online and live testimony in support of this report. Your Reference Committee recommends that Council Report 6 be adopted.

- (6) COUNCIL ON MEDICAL EDUCATION REPORT 8 – CHALLENGES TO PRIMARY SOURCE VERIFICATION OF INTERNATIONAL MEDICAL GRADUATES RESULTING FROM INTERNATIONAL CONFLICT

RECOMMENDATION:

Recommendations in Council on Medical Education Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 8 adopted and the remainder of the report 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 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)~~

CME 8-A-23 received online and live testimony in support of this report. Your Reference Committee recommends that Council Report 8 be adopted.

- (7) COUNCIL ON MEDICAL EDUCATION REPORT 9 – THE IMPACT OF MIDLEVEL PROVIDERS ON MEDICAL EDUCATION (RESOLUTION 201-A-22)

RECOMMENDATION:

Recommendations in Council on Medical Education Report 9 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 9 adopted and the remainder of the report filed.

1. Our American Medical Association encourages 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.
2. Our AMA encourages medical educators to study how interprofessional learning and teamwork promote the development of physician leadership in team-based care.
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. 07

CME 9-A-23 received online and live testimony in support of this report. Your Reference Committee recommends that Council Report 9 be adopted.

- (8) RESOLUTION 320 – BANNING AFFIRMATIVE ACTION IS A CRITICAL THREAT TO HEALTH EQUITY AND TO THE MEDICAL PROFESSION

RECOMMENDATION:

Resolution 320 be adopted.

HOD ACTION: Resolution 320 adopted.

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 proactively implement policies and procedures that operationalize race-conscious admission practices in admissions decisions, among other factors.

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 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.

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)

Resolution 320 received testimony in support of the proposed amendments to Policies H-350.979 and D-200.985 as well as one new resolve. Your Reference Committee recommends that Resolution 320 be adopted.

RECOMMENDED FOR ADOPTION WITH A TITLE CHANGE

- (9) RESOLUTION 302 – ANTITRUST LEGISLATION REGARDING THE AAMC, ACGME, NRMP, AND OTHER RELEVANT ASSOCIATIONS OR ORGANIZATIONS

RECOMMENDATION A:

Resolution 302 be adopted.

RECOMMENDATION B:

The title of Resolution 302 be changed, to read as follows:

STUDY OF THE CURRENT MATCH PROCESS AND ALTERNATIVES

HOD ACTION: Resolution 302 adopted with a change in title to read as follows:

STUDY OF THE CURRENT MATCH PROCESS AND ALTERNATIVES

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)

Resolution 302 received mixed online and live testimony on this item. Testimony by the National Resident Matching Program (NRMP) noted concerns about the perception of its role, the accuracy and implications of the statements of the resolution, and possible conflict with AMA policy. The authors of this resolution acknowledged the testimony of the NRMP but maintained support of the resolution as written. The Council on Medical Education offered testimony in support of a study to look more closely at this issue and address concerns. Further, your Reference Committee felt it was appropriate to change the title to better reflect the resolve. Your Reference Committee appreciates the Council's willingness to study the topic and recommends that Resolution 302 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (10) COUNCIL ON MEDICAL EDUCATION REPORT 2 – FINANCING
MEDICAL EDUCATION (RESOLUTION 306-A-22)

RECOMMENDATION A:

Council on Medical Education Report 2 be amended by the addition of a fifth Recommendation, to read as follows:

5. That our AMA support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt. (New HOD Policy)

RECOMMENDATION B:

Recommendations in Council on Medical Education Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 2 adopted as amended and the remainder of the report 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)

Your Reference Committee received online and live testimony largely in favor of this report. Regarding the Medical Student Section’s proposed amendment, the Council on Medical Education noted that “non-educational debt” could be interpreted very broadly (e.g., mortgage, car loan, etc.) and go beyond the purview of the AMA. Other testimony supported ongoing efforts to reduce non-educational debt but did not support efforts to seek forgiveness of non-educational debt.

Testimony by the New York Delegation proffered a new fourth recommendation to “support federal efforts to forgive debt incurred during medical school and college by physicians and medical students, including educational and cost of attendance debt.” Additional testimony reflected a desire for the report to go further with regards to action toward advocating for debt cancellation and federal loan forgiveness. Your Reference Committee concurs and recommends that Council Report 2 be adopted as amended.

- (11) RESOLUTION 304 – INCREASING ACCESS TO GENDER-AFFIRMING PROCEDURES THROUGH EXPANDED TRAINING AND EQUITABLE REIMBURSEMENT

RECOMMENDATION A:

The first Resolve of Resolution 304 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA ~~advocate for encourage interested parties, including medical schools, relevant specialty residency/fellowship programs, professional associations, and regulatory bodies to increase opportunities for expanded structured training for education in gender-affirming care for both practicing physicians and students/trainees 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

RECOMMENDATION B:

The second Resolve of Resolution 304 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.

RECOMMENDATION C:

Resolution 304 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 304 be changed, to read as follows:

INCREASING ACCESS TO GENDER-AFFIRMING CARE THROUGH EXPANDED TRAINING AND EQUITABLE COVERAGE

HOD ACTION: Resolution 304 adopted as amended with a change in title, to read as follows:

The second Resolve of Resolution 304 amended by addition and deletion, to read as follows:

RESOLVED, That our AMA advocate for equitable coverage reimbursement of evidence-based gender-affirming care procedures by health insurance providers, including public and private insurers. (Directive to Take Action)

INCREASING ACCESS TO GENDER-AFFIRMING CARE THROUGH EXPANDED TRAINING AND EQUITABLE COVERAGE

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)

Resolution 304 received predominantly supportive online and live testimony, including amendments to the resolves and title to address the full spectrum of medical, psychosocial, and procedural care that encompasses gender-affirming care. The author supported these amendments. Further, the Council on Medical Education offered amendments to clarify the first resolve. The Council on Medical Service also testified in support of the spirit of the resolution and offered an amendment to the second resolve to “support evidence-based coverage of gender-affirming health care, including procedures, by public and private health insurance.” Your Reference Committee agrees and recommends that Resolution 304 be adopted as amended.

- (12) RESOLUTION 305 – INDIAN HEALTH SERVICE GRADUATE MEDICAL EDUCATION

RECOMMENDATION A:

The first Resolve of Resolution 305 be **amended by addition and deletion**, to read as follows:

Our American Medical Association will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

RECOMMENDATION C:

Resolution 305 be adopted as amended.

HOD ACTION: Resolution 305 adopted as amended

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)

Resolution 305 received supportive online and live testimony. The Council on Medical Education offered amendments to both resolves to clarify intent. Testimony also suggested that Section 403 of the Mission Act, which explores funding GME training off the traditional Veterans Affairs campus at Indian Health Service and other tribal health care facilities, addresses the second resolve. Reference Committee review of Section 403 showed that it is a pilot program that only partially addresses the ask in the second resolve. Other testimony supported funding streams for additional educational opportunities. Therefore, your Reference Committee recommends that Resolution 305 be adopted as amended.

- (13) RESOLUTION 306 – INCREASED EDUCATION AND ACCESS TO FERTILITY RESOURCES FOR U.S. MEDICAL STUDENTS

RECOMMENDATION A:

The first Resolve of Resolution 306 be **amended by addition and deletion**, to read as follows:

Our American Medical Association will encourage interested parties 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.

Our AMA will encourage interested parties 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.

RECOMMENDATION C:

Resolution 306 be adopted as amended.

HOD ACTION: Resolution 306 adopted as amended.

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)

Resolution 306 received online and live testimony in support of this item. The Council on Medical Education was concerned that the first resolve might imply a medical education mandate; however, the Council expressed support for the second resolve. Your Reference Committee appreciates the Council's concerns and therefore has proposed amendments to the first resolve to remove the perceived mandate. In addition, your Reference Committee recommends inclusion of all interested parties in this work and that Resolution 306 be adopted as amended.

- (14) RESOLUTION 307 – 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

RECOMMENDATION A:

The first Resolve of Resolution 307 be amended by addition and deletion, to read as follows:

3. Our AMA encourages undergraduate and graduate medical education programs to create mental health substance use 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.**

RECOMMENDATION B:

Resolution 307 be adopted as amended.

HOD ACTION: Resolution 307 adopted as amended.

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 Physicians 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)

Resolution 307 seeks to amend the third clause of AMA Policy H-295.858. This item received supportive online and live testimony. Testimony also referenced the timeliness of this resolution in light of a recent resident suicide and noted institutional success in offering support services through dedicated counseling and psychological services (e.g., CAPS) instead of traditional student health services. The Council on Medical Education offered an amendment to the third clause of Policy H-295.858 to explicitly include undergraduate and graduate medical education. Additional testimony also offered amendments to amend “substance abuse” to the more appropriate term “substance use.” Your Reference Committee agrees and recommends that Resolution 307 be adopted as amended.

- (15) RESOLUTION 311 – RESIDENCY APPLICATION SUPPORT FOR STUDENTS OF LOW-INCOME BACKGROUNDS

RECOMMENDATION A:

The first Resolve of Resolution 311 be amended by deletion, to read as follows:

~~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~~

RECOMMENDATION B:

The second Resolve of Resolution 311 be amended by addition, to read as follows:

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 or are determined to have financial need through another formal mechanism. (New HOD Policy)

RECOMMENDATION C:**Resolution 311 be adopted as amended.****HOD ACTION: Resolution 311 adopted as amended.**

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)

Resolution 311 received mixed testimony. While some testimony supported the entire item, others opposed the first resolve, noting possible unintended consequences of a no-cost application process. The Council on Medical Education suggested that the two resolves were not in alignment; hence, they recommended that the first resolve not be adopted and the second be amended to clarify the determination of financial need. The Council also referenced its new report, CME 2-A-23, as providing a comprehensive review of the current status of medical education financing. Your Reference Committee is sensitive to the concerns of the author and also appreciates the Council's guidance. Your Reference Committee therefore recommends that Resolution 311 be adopted as amended.

- (16) RESOLUTION 314 - SUPPORT FOR INTERNATIONAL MEDICAL GRADUATES FROM TURKEY

RECOMMENDATION A:

The first Resolve of Resolution 314 be amended by deletion, to read as follows:

~~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~~

RECOMMENDATION B:

The second Resolve of Resolution 314 be amended by deletion, to read as follows:

~~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~~

RECOMMENDATION C:

Resolution 314 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 314 be changed, to read as follows:

SUPPORT FOR INTERNATIONAL MEDICAL GRADUATES FROM COUNTRIES FACING MAJOR HUMANITARIAN CRISES

HOD ACTION: Resolution 314 adopted as amended with a change in title, to read as follows.

The third Resolve of Resolution 314 amended by addition, to read as follows:

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, regardless of their country's political alignment, to promote an understanding of the challenges specific to immigrant physicians (Directive to Take Action); and be it further

SUPPORT FOR INTERNATIONAL MEDICAL GRADUATES FROM COUNTRIES FACING MAJOR HUMANITARIAN CRISES

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)

Resolution 314 received testimony acknowledging the impact on IMGs of humanitarian crises that may occur in their country of origin, and thus were in support of the third and fourth resolves, but in opposition to the first and second resolves. Testimony expressed concern that the first resolve is too narrowly focused on only the terrible events in Turkey, and the second resolve presents unclear fiscal implications. Your Reference Committee agrees with the testimony and recommends that Resolution 314 be adopted as amended, with deletion of the first and second resolves.

- (17) RESOLUTION 316 – PHYSICIAN MEDICAL CONDITIONS AND QUESTIONS ON APPLICATIONS FOR MEDICAL LICENSURE, SPECIALTY BOARDS, AND INSTITUTIONAL PRIVILEGES

RECOMMENDATION A:

Resolution 316 be amended by addition and deletion, to read as follows:

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 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 their judgment or that would otherwise adversely affect their 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 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 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.

RECOMMENDATION B:

Resolution 316 be adopted as amended.

HOD ACTION: Resolution 316 adopted as amended

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)

Resolution 316 seeks to amend AMA Policy H-275.970. This item received supportive testimony. The Council on Medical Education offered testimony that concurred with the author’s amendments to the first clause but recommended changing the author’s amendment in the second clause from “will verify that” to “encourage” given the AMA’s lack of authority or ability to verify. The Council also recommended removal of “by 2024” in the second and third resolves because the AMA lacks the authority to impose such a deadline. In addition, your Reference Committee recommended the use of gender-neutral language. Further testimony supported the Council’s testimony, including that of the Council on Legislation. Your Reference Committee appreciates the input of these Councils and recommends that Resolution 316 be adopted as amended.

- (18) RESOLUTION 319 – SUPPORTING DIVERSITY, EQUITY, & INCLUSION OFFICES AND INITIATIVES AT UNITED STATES MEDICAL SCHOOLS TO ENHANCE LONGITUDINAL COMMUNITY ENGAGEMENT

RECOMMENDATION A:

The third Resolve of Resolution 319 be amended by addition and deletion, to read as follows:

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 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; (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; and (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty.

RECOMMENDATION B:**Resolution 319 be adopted as amended.****HOD ACTION: Resolution 319 adopted as amended**

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.

Resolution 319 offered two new resolves as well as amendments to AMA Policy D-295.963. While the abundance of testimony supported this resolution, concern was raised as to its potential impact on some states where funding may be affected. An amendment of an additional clause was offered to investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty. The author of the resolution accepted this amendment. Therefore, your Reference Committee recommends that Resolution 319 be adopted as amended.

(19) RESOLUTION 321 – CORPORATE COMPLIANCE CONSOLIDATION

RECOMMENDATION A:

The first Resolve of Resolution 321 be amended by deletion, to read as follows:

~~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~~

RECOMMENDATION B:

The second Resolve of Resolution 321 be amended by addition and deletion, to read as follows:

Our American Medical Association encourages reciprocity for corporate compliance curricula between institutions to minimize duplicate training and assessment of physicians.

RECOMMENDATION C:

Resolution 321 be adopted as amended.

HOD ACTION: Resolution 321 adopted as amended.

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)

Resolution 321 received mixed testimony, noting physicians' frustration of having to complete corporate compliance education requirements from multiple institutions as well as desire for a universal solution to address what is seen as a duplicative unfunded mandate on physicians' time and resources. Testimony expressed the lack of feasibility in being able to implement a standard curriculum that appeases all institutions and employers—each with their own legal requirements. Your Reference Committee noted that the second resolve appears predicated on the success of the first resolve, which testimony noted may not be feasible. Understanding the spirit of this resolution and frustrations expressed, your Reference Committee clarified the language to accomplish the goal of reciprocity to reduce redundancies and preserve physician time and effort. Therefore, your Reference Committee recommends that Resolution 321 be adopted as amended.

- (20) RESOLUTION 322 – DISCLOSURE OF COMPLIANCE ISSUES AND CREATING A NATIONAL DATABASE OF JOINT LEADERSHIP

RECOMMENDATION A:

The first Resolve of Resolution 322 be amended by addition and deletion, to read as follows:

Our American Medical Association encourages the Accreditation Council for Continuing Medical Education to ask accredited CME providers to include in their CME applications for joint providership a question about past denial(s) for accreditation.

~~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)~~

RECOMMENDATION C:

Resolution 322 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 322 be changed, to read as follows:

DISCLOSURE OF COMPLIANCE ISSUES RELATED TO JOINT PROVIDERSHIP

HOD ACTION: Resolution 322 adopted as amended with a change in title:

DISCLOSURE OF COMPLIANCE ISSUES RELATED TO JOINT PROVIDERSHIP

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)

Testimony on Resolution 322 noted that the ACCME does not have any information on organizations that are not ACCME-accredited, so there would be no way to compile the data requested in the second resolve. The Council on Medical Education recommended that the first resolve be amended to encourage the ACCME to ask accredited CME providers about past denial(s) for accreditation in their CME applications for joint providership. The Council suggested the second resolve not be adopted as it is predicated on the first resolve and not something the ACCME can institute since they do not have purview over nonaccredited organizations seeking joint providership. Resolution 322 received testimony from the author suggesting a change in title from “joint leadership” to “joint providership.” Your Reference Committee was informed that “joint providership” is when an ACCME-accredited CME provider partners with a non-accredited organization on a learning activity. Your Reference Committee concurs with the guidance of the Council and therefore recommends that Resolution 322 be adopted as amended.

- (21) RESOLUTION 323 – AMEND POLICY D-275.948, “EDUCATION, TRAINING AND CREDENTIALING OF NON-PHYSICIAN HEALTH CARE PROFESSIONALS AND THEIR IMPACT ON PHYSICIAN EDUCATION AND TRAINING”

RECOMMENDATION A:

Resolution 323 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA amend policy D-275.948 by addition to read as follows:

1.) Our AMA acknowledges that a conflict of interest exists when non-physician health care professionals hold positions on physician regulatory bodies or physician boards when these individuals represent a field that either possesses or seeks to possess the ability to practice without physician supervision; and 2). Our AMA will encourage key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to: (1) increase transparency of the process by encouraging them to openly disclose how their board is composed and members are selected; and (2) review and amend their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision.

RECOMMENDATION B:**Resolution 323 be adopted as amended.****HOD ACTION: Resolution 323 adopted as amended.**

RESOLVED, That our AMA amend policy D-275.948 by addition to read as follows:

1.) Our AMA acknowledges that a conflict of interest exists when non-physician health care professionals hold positions on physician regulatory bodies or physician boards when these individuals represent a field that either possesses or seeks to possess the ability to practice without physician supervision; and

2.) Our AMA will work with and advocate to key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to: (1) increase transparency of the process by encouraging them to openly disclose how their board is composed and members are selected; and (2) review and amend their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision; and

3.) Our AMA opposes any non-physician having a voting position on a regulatory body or physician board responsible for physician education, accreditation, certification, licensing, or credentialing.

This resolution received testimony expressing concerns about conflict of interest and scope issues, while also expressing the value of the representation of public members on boards. Your Reference Committee noted that a resolution on this issue was brought forth to the 2021 Special June Meeting, including language similar to the third resolve of this resolution, and was referred. The Council on Medical Education studied the issue and submitted CME 5-A-22, which was subsequently adopted by the HOD, resulting in D-275.948—the policy this resolution seeks to amend. The Council on Medical Education offered testimony in support of the new first clause from the author. They offered further amendments to the second clause, suggesting the AMA “encourage” key regulatory bodies. Also, they noted continued concerns about the third resolve, which was not adopted at J-21, given potential negative implications for key interested parties and relationships, and suggested it not be adopted. Your Reference Committee agrees with the Council and recommends that Resolution 323 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (22) COUNCIL ON MEDICAL EDUCATION REPORT 7 – MANAGEMENT AND LEADERSHIP TRAINING IN MEDICAL EDUCATION

RESOLUTION 318 – FOSTERING PATHWAYS FOR RESIDENT PHYSICIANS TO PURSUE MBA PROGRAMS IN ORDER TO INCREASE THE NUMBER OF QUALIFIED PHYSICIANS FOR HEALTHCARE LEADERSHIP POSITIONS

RECOMMENDATION:

Recommendations in Council on Medical Education Report 7 be adopted in lieu of Resolution 318 and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 7 adopted in lieu of Resolution 318 and the remainder of the report 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 development 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.

Resolution 318:

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)

CME 7-A-23 received online and live testimony in support of this report. The Council on Medical Education noted that this report is aligned with the spirit of Resolution 318, both of which support leadership education. While Resolution 318 addresses additional training, the Council report is broader and encourages various pathways of learning in leadership and management. Your Reference Committee agrees and recommends that Council Report 7 be adopted in lieu of Resolution 318.

- (23) RESOLUTION 301 – INCREASING MUSCULOSKELETAL EDUCATION IN PRIMARY CARE SPECIALTIES AND MEDICAL SCHOOL EDUCATION THROUGH INCLUSION OF OSTEOPATHIC MANUAL THERAPY EDUCATION

RESOLUTION 310 – TEACHING AND ASSESSING OSTEOPATHIC MANIPULATIVE TREATMENT AND OSTEOPATHIC PRINCIPLES AND PRACTICE TO RESIDENT PHYSICIANS IN THE CONTEXT OF ACGME SINGLE SYSTEM OF ACCREDITATION

RECOMMENDATION A:

Alternate Resolution 301 be adopted in lieu of Resolutions 301 and 310, to read as follows:

Our American Medical Association will 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.

Our AMA will encourage physician awareness of the benefits of evidence-based Osteopathic Manipulative Medicine for musculoskeletal conditions.

Our AMA will collaborate with the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other interested parties to assess the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Medicine across ACGME-accredited residency programs.

RECOMMENDATION B:

The title of Resolution 301 be changed, to read as follows:

Teaching and Assessing Osteopathic Manipulative Medicine and Osteopathic Principles and Practice

HOD ACTION: Alternate Resolution 301 adopted in lieu of Resolutions 301 and 310, to read as follows with a change in title:

RESOLVED, That our American Medical Association (AMA) 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 AMA encourage physician awareness of the benefits of evidence-based Osteopathic Manipulative Medicine for musculoskeletal conditions (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other interested parties to assess the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Medicine across ACGME-accredited residency programs. (New HOD Policy)

**TEACHING AND ASSESSING OSTEOPATHIC MANIPULATIVE
MEDICINE AND OSTEOPATHIC PRINCIPLES AND PRACTICE**

Resolution 301:

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)

Resolution 310:

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)

Resolution 301 received predominantly supportive online and live testimony. The American Osteopathic Association (AOA) and Student Osteopathic Medical Association offered amendments to correct terminology. The Council on Medical Education offered alternate language to combine Resolutions 301 and 310. Testimony supported the evidence base for Osteopathic Manipulative Medicine (OMM). The American Osteopathic Association (AOA) testified that OMM is separate and unique from physical and occupational therapy. Testimony was also supportive of all physicians being exposed to osteopathic training so that they might better understand the differences in treatment. Your Reference Committee concurred with combining resolutions since they both address osteopathic medicine, appreciates the clarification of terminology by AOA, and agrees with the alternate language provided by the Council. Therefore, your Reference Committee recommends that alternate Resolution 301 be adopted in lieu of Resolutions 301 and 310.

- (24) RESOLUTION 308 – INCREASED INCLUSIVITY AND ADMISSION POLICIES CLARIFICATION FOR DACA MEDICAL SCHOOL AND RESIDENCY APPLICANTS

RECOMMENDATION A:

Alternate Resolution 308 be adopted in lieu of Resolution 308, to read as follows:

RESOLVED, That our AMA (a) commend the Association of American Medical Colleges (AAMC) for its collection of data on medical schools that accept applicants eligible for Deferred Action for Childhood Arrivals (DACA) and encourage ongoing data collection; (b) request that the AAMC expand its data collection to include financial assistance options for DACA-eligible students; and (c) publicize and disseminate this information to interested parties. (Directive to Take Action)

RECOMMENDATION B:

The title of Resolution 308 be changed, to read as follows:

INCREASED INCLUSIVITY AND ADMISSION POLICIES CLARIFICATION FOR DACA-ELIGIBLE MEDICAL SCHOOL AND RESIDENCY APPLICANTS

HOD ACTION: Alternate Resolution 308 be adopted in lieu of Resolution 308, to read as follows with a change in title:

Our American Medical Association will (a) commend the Association of American Medical Colleges (AAMC) for its collection of data on medical schools that accept applicants eligible for Deferred Action for Childhood Arrivals (DACA) and encourage ongoing data collection; (b) request that the AAMC expand its data collection to include financial assistance options for DACA-eligible students; and (c) publicize and disseminate this information to interested parties.

**INCREASED INCLUSIVITY AND ADMISSION POLICIES
CLARIFICATION FOR DACA-ELIGIBLE 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)

Resolution 308 received mixed online and live testimony on this item. Testimony expressed concern for the potential unintended consequences of collecting data on DACA-eligible applicants, in particular potential discrimination against these applicants and cessation of funds to institutions who educate and train these applicants. Testimony was also given to express support for increased transparency from institutions that are willing to receive DACA-eligible applicants. Your Reference Committee recognizes this is a complex issue and identified existing resources for DACA-eligible applicants, such as the 2024 AAMC Medical School Admission Requirements™ (MSAR®) Report for Applicants and Advisors for Deferred Action for Childhood Arrivals (DACA). Your Reference Committee appreciates the spirit of the author's intent and proposes an amendment to prioritize the safety of DACA-eligible applicants. Your Reference Committee recommends that Resolution 308 be adopted as amended.

(25) **RESOLUTION 309 – AGAINST LEGACY PREFERENCES AS A FACTOR
IN MEDICAL SCHOOL ADMISSIONS**

RECOMMENDATION:

Alternate Resolution 309 be adopted in lieu of Resolution 309, to read as follows:

RESOLVED, That our AMA recognize that legacy status may be one of many stated reasons an applicant may offer for interest in a particular medical school. Medical schools are encouraged to avoid specific questions about legacy status in their application process. (New HOD Policy)

HOD ACTION: Alternate Resolution 309 adopted in lieu of Resolution 309, to read as follows:

Our American Medical Association recognizes that legacy status may be one of many stated reasons an applicant may offer for interest in a particular medical school, but oppose the use of questions about legacy status in the medical school application process due to their discriminatory impact.

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)

Your Reference Committee heard testimony in support of this resolution. The authors testified as to the serious threat to medical student diversity posed by legacy admissions to medical school. They stated that the AMA “has championed policies that speak to the eradication of discriminatory practices in medical school admissions” and called for attention to legacy admissions as a critical aspect to further this work. Testimony reflected that legacy applicants benefit from a discriminatory practice, which should be ended to improve access for historically marginalized populations applying to medical school. The Council on Medical Education called for a nuanced view, such that an applicant could volunteer this information, while opposing the school specifically asking about legacy status in the application. Additional testimony also reflected that a study of the issue would not uncover any new or actionable information or data and might delay AMA action on this front. Accordingly, your Reference Committee recommends adoption of the alternate language as proposed.

(26) RESOLUTION 312 – INDIAN HEALTH SERVICE LICENSING EXEMPTIONS

RECOMMENDATION:

Alternate Resolution 312 be adopted in lieu of Resolution 312, to read as follows:

RESOLVED, That our AMA work with interested parties to evaluate existing regulatory and licensure opportunities and barriers to physician participation in health care services for Native Americans, Alaska Natives, and Native Hawaiians. (Directive to Take Action)

HOD ACTION: Alternate Resolution 312 adopted in lieu of Resolution 312, to read as follows:

RESOLVED, That our AMA work with interested parties to evaluate existing regulatory and licensure opportunities and barriers to physician participation in health care services for Native Americans, Alaska Natives, and Native Hawaiians. (Directive to Take Action)

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)

Resolution 312 received testimony expressing concern for issues facing physicians at Indian Health Service as well as Tribal and Urban Indian Health Programs. The Council on Medical Education noted that the first resolve references “federally licensed”; however, there is no federal licensure since only states license physicians. Federally employed physicians can use their state license in any federal facility across the country. The Council supported the spirit of the resolution, but noted concern that it may not represent all the affected communities. Therefore, the Council offered alternate language to clarify the issue and demonstrate support. The Board of Trustees offered testimony in strong support of the author’s intentions as well as the Council’s alternate language. Your Reference Committee understands the concerns of the author and appreciates the Council’s alternate language, which provides a more actionable approach to this issue, and therefore recommends adoption of alternate Resolution 312 in lieu of the original item.

- (27) RESOLUTION 313 – FILTERING INTERNATIONAL MEDICAL GRADUATES DURING RESIDENCY OR FELLOWSHIP APPLICATIONS

RESOLUTION 315 – PROHIBIT DISCRIMINATORY ERAS® FILTERS IN NRMP MATCH

RECOMMENDATION:

Alternate Resolution 313 be adopted in lieu of Resolutions 313 and 315, to read as follows:

RESOLVED, That our AMA recognize the exclusion of certain residency applicants from consideration, such as international medical graduates (New HOD Policy); and be it further

RESOLVED, That our AMA oppose discriminatory use of filters designed to inequitably screen applicants using the Electronic Residency Application Service® (ERAS®) system. (Directive to Take Action)

HOD ACTION: Alternate Resolution 313 adopted in lieu of Resolutions 313 and 315, to read as follows:

Our American Medical Association recognizes the exclusion of certain residency applicants from consideration, such as international medical graduates.

Our AMA opposes discriminatory use of filters designed to inequitably screen applicants, including international medical graduates, using the Electronic Residency Application Service® (ERAS®) system.

Resolution 313:

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)

Resolution 315:

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)

Resolution 313 received favorable testimony, including testimony from the author that supported combining this item with Resolution 315, given the similarities of the respective items.

Resolution 315 received significant supportive testimony. Like Resolution 313, the author of Resolution 315 also supported combining the two items into one. The Council on Medical Education concurred and offered alternate language to aid in this goal, while strongly opposing the use of filters that discriminate against marginalized medical school graduates, including international medical graduates. Your Reference Committee believes in equity for all medical graduates and therefore recommends that alternate Resolution 313 be adopted in lieu of original Resolutions 313 and 315.

RECOMMENDED FOR REFERRAL FOR DECISION**(28) RESOLUTION 303 – MEDICAL SCHOOL MANAGEMENT OF UNMATCHED MEDICAL STUDENTS****RECOMMENDATION:****Resolution 303 be referred for decision.****HOD ACTION: Resolution 303 referred for decision.**

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)

Resolution 303 received online and live testimony on this item. While this resolution asks for a task force, the Council on Medical Education shared that such a body exists in the form of the Coalition for Physician Accountability, of which the AMA is an active member. The Coalition's UME-to-GME Review Committee (UGRC) issued recommendations on this topic. The Council also noted that the AMA has several policies that address the various aspects of this resolution, and that they should be reaffirmed in lieu of this resolution to avoid duplicative policy. The New England Delegation testified that the recommendations of the UGRC focus on the transition from undergraduate medical education to graduate medical education and did not think this reflected the intent of the resolution. Your Reference Committee believes this is a complex issue involving multiple interested parties with diverse viewpoints that need to be considered and recognizes this is an urgent problem that highlights a misattunement of need and resources. Your Reference Committee is also concerned that the right mechanism to address the concerns of the resolution is unknown, and therefore recommends that Resolution 303 be referred for decision.

REPORT OF REFERENCE COMMITTEE D

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 17 - AMA Public Health Strategy
2. Resolution 406 - Increase Employment Services Funding for People with Disabilities
3. Resolution 410 - Formal Transitional Care Program for Children and Youth with Special Health Care Needs
4. Resolution 416 - New Policies to Respond to the Gun Violence Public Health Crisis
5. Resolution 419 - Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System
6. Resolution 420 - Foster Health Care
7. Resolution 424 - Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home
8. Resolution 434 – Improving Hazardous Chemical Transport Regulations for Public Health Protections
9. Resolution 435 – Stand Your Ground Laws
10. Resolution 436 – Prediabetes as a Major Health Concern for Chronic Disease Prevention

RECOMMENDED FOR ADOPTION AS AMENDED

11. Council on Science and Public Health Report 5 - Increasing Public Umbilical Cord Blood Donation in Transplant Centers
12. Council on Science and Public Health Report 7 - 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
13. Council on Science and Public Health Report 8 - Council on Science and Public Health Sunset Review of 2013 House Policies
14. Resolution 402 - Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance
15. Resolution 403 - Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
16. Resolution 404 - Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers
17. Resolution 405 - Amendment to AMA Policy “Firearms and High-Risk Individuals H-145.972” to Include Medical Professionals as a Party Who Can Petition the Court
18. Resolution 407 - Addressing Inequity in Onsite Wastewater Treatment
19. Resolution 411 - Protecting Workers During Catastrophes
20. Resolution 413 - Supporting Intimate Partner and Sexual Violence Safe Leave
21. Resolution 414 - Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population
22. Resolution 415 - Environmental Health Equity in Federally Subsidized Housing
23. Resolution 417 - Treating Social Isolation and Loneliness as a Social Driver of Health
24. Resolution 418 - Increasing the Availability of Automated External Defibrillators
25. Resolution 421 - Prescribing Guided Physical Activity for Depression and Anxiety
26. Resolution 425 - Examining Policing Through a Public Health Lens
27. Resolution 427 - Minimizing the Influence of Social Media on Gun Violence
28. Resolution 428 - Mattress Safety in the Hospital Setting
29. Resolution 429 - Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System
30. Resolution 430 - Teens and Social Media
31. Resolution 431 - Qualified Immunity Reform
32. Resolution 433 - Upholding Scientifically and Medically Valid Practices for Blood Transfusions

RECOMMENDED FOR ADOPTION IN LIEU OF

33. Council on Science and Public Health Report 4 - School Resource Officer Violence De-escalation Training and Certification
Resolution 408 - School-to-Prison Pipeline
34. Council on Science and Public Health Report 6 - Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections
Resolution 432 - Correctional Medicine
35. Resolution 401 - Metered Dose Inhalers and Greenhouse Gas Emissions
36. Resolution 412 - Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal
37. Resolution 422 - National Emergency for Children

RECOMMENDED FOR REFERRAL

38. Resolution 423 - Reducing Sodium Intake to Improve Public Health

RECOMMENDED FOR REFERRAL FOR DECISION

39. Resolution 409 - Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training

RECOMMENDED FOR NOT ADOPTION

40. Resolution 426 - Accurate Abortion Reporting with Demographics by the Center for Disease Control

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 17 – AMA PUBLIC HEALTH STRATEGY

RECOMMENDATION:

Recommendations in Board of Trustees Report 17 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 17 adopted and the remainder of the report filed.

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.

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.

Your Reference Committee heard testimony that was mostly supportive of Board of Trustees Report 17. Testimony noted that responding to public health crises such as climate change and firearm violence are an important focus for advancing our AMA's mission and there was appreciation for the Board putting forth a comprehensive report on public health. Some who testified asked for referral of the report back to the Board for a more comprehensive approach specific to the climate crisis. Since this will be a yearly report to the House, your Reference Committee urges adoption of this report, with strong encouragement for the Board to include additional details on the climate strategy and metrics for accountability in their upcoming report to the House. Testimony was also offered encouraging additional funding to support public health infrastructure and preventive medicine residency programs and universal access to essential public health services. However, existing policies D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion," D-305.974, "Funding for Preventive Medicine Residencies," D-440.922, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems," and D-440.924, "Universal Access for Essential Public Health Services" already address these asks. Therefore, Your Reference Committee recommends adoption of this report.

- (2) RESOLUTION 406 – INCREASE EMPLOYMENT SERVICES FUNDING FOR PEOPLE WITH DISABILITIES

RECOMMENDATION:

Resolution 406 be adopted.

HOD ACTION: Resolution 406 adopted.

RESOLVED, That our American Medical Association support increased resources for employment services to reduce health disparities for people with disabilities. (New HOD Policy)

Your Reference Committee heard limited but supportive testimony on Resolution 406. It was noted that some of the challenges people with disabilities faced in the workplace may have simple solutions and increasing employment resources often results in productive employment. Therefore, your Reference Committee recommends that Resolution 406 be adopted.

- (3) RESOLUTION 410 – FORMAL TRANSITIONAL CARE PROGRAM FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

RECOMMENDATION:

Resolution 410 be adopted.

HOD ACTION: Resolution 410 adopted.

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)

Your Reference Committee heard limited, but supportive testimony for this resolution that expands existing policy on children and youth with disabilities to children with youth and special healthcare needs. Therefore, your Reference Committee recommends that Resolution 410 be adopted.

- (4) RESOLUTION 416 – NEW POLICIES TO RESPOND TO THE GUN VIOLENCE PUBLIC HEALTH CRISIS

RECOMMENDATION:

Resolution 416 be adopted.

HOD ACTION: Resolution 416 adopted.

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)

Your Reference Committee heard testimony mostly in support of Resolution 416. The policies outlined in this resolution to strengthen background checks and prevent sales of multiple firearms to the same purchaser within a short period of time are important policies to address firearm violence. Additional testimony noted that the expansion of

background checks to include inheritance, gifting, or transfer of ownership of firearms and ammunition helps advance the common goal of preventing firearm injuries. Limited opposing testimony was heard, and minimal changes suggested that did not substantively change the resolution. Given the overwhelming supportive testimony, your Reference Committee recommends that Resolution 416 be adopted.

- (5) RESOLUTION 419 – INCREASED SUICIDE RISK FOR CHILDREN, YOUTHS, AND YOUNG ADULTS IN THE WELFARE SYSTEM

RECOMMENDATION:

Resolution 419 be adopted.

HOD ACTION: Resolution 419 adopted.

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)

Your Reference Committee heard testimony in support of Resolution 419. The amendment to existing policy is designed to bring attention to the dramatic rise in child suicide, which is an important issue that urgently needs to be addressed. Therefore, your Reference Committee recommends that Resolution 419 be adopted.

(6) RESOLUTION 420 – FOSTER HEALTH CARE

RECOMMENDATION:**Resolution 420 be adopted.****HOD ACTION: Resolution 420 adopted.**

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-informed care that addresses the specific mental, developmental, and physical health care needs of children in foster care. (Directive to Take Action)

Your Reference Committee heard testimony from the author in support of this resolution. Your Reference Committee agrees that this is an important amendment to existing policy and therefore recommends that Resolution 420 be adopted.

(7) RESOLUTION 424 – JOB SECURITY RELATED TO LEAVE FOR CAREGIVER WHEN A CHILD IN FOSTER CARE IS PLACED IN THEIR HOME

RECOMMENDATION:**Resolution 424 be adopted.****HOD ACTION: Resolution 424 adopted.**

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)

Your Reference Committee heard testimony that was unanimously supportive of this resolution. It was noted that this resolution covers an important and impactful gap in current policy and is a critical step to increase retention and support for foster families. Therefore, your Reference Committee recommends that Resolution 424 be adopted.

- (8) RESOLUTION 434 – IMPROVING HAZARDOUS CHEMICAL TRANSPORT REGULATIONS FOR PUBLIC HEALTH PROTECTIONS

RECOMMENDATION:

Resolution 434 be adopted.

HOD ACTION: Resolution 434 adopted.

RESOLVED, That our AMA amend H-135.993 by addition to read as follows:

H-135.993 ~~Transportation and Storage of~~ Regulating Hazardous Materials to Protect Public Health

Our AMA (1) requests governmental agencies to develop adequate systems, which include instruction for detoxification or neutralization in event of emergencies, for continuous monitoring of transportation and storage of hazardous materials-, (2) advocates for regulations that govern the transportation of hazardous materials to prioritize public health and safety over cost or other considerations, (3) supports efforts to hold companies that are responsible for chemical spills liable for the cost of healthcare incurred by people exposed to hazardous chemicals, and (4) supports the creation of a registry for people affected by hazardous chemical exposures in order to monitor the health effects of these exposures, with cohort reports released as appropriate.

Your Reference Committee heard mostly supportive testimony of Resolution 434. An individual cautioned that too much regulation of transportation could bring the industry to a halt. However, your Reference Committee determined that given recent events and the narrow focus of the resolution on the transportation of hazardous materials, additional attention is warranted. Therefore, your Reference Committee recommends that Resolution 434 be adopted.

- (9) RESOLUTION 435 – STAND YOUR GROUND LAWS

RECOMMENDATION:

Resolution 435 be adopted.

HOD ACTION: Resolution 435 adopted.

RESOLVED, That our AMA study the public health implications of “Stand Your Ground” laws and castle doctrine.

Your Reference Committee heard limited positive testimony in support of this item. Therefore, your Reference Committee recommends that Resolution 435 be adopted.

- (10) RESOLUTION 436 – PREDIABETES AS A MAJOR HEALTH CONCERN FOR CHRONIC DISEASE PREVENTION

RECOMMENDATION:

Resolution 436 be adopted.

HOD ACTION: Resolution 436 adopted.

RESOLVED, Our AMA acknowledges prediabetes as a major health concern for chronic disease prevention in the United States, and supports development of physician and patient focused education, increased access to care and continued advocacy for local, state and nation-wide policy change within a diversity, equity, inclusion and accessibility framework.

Your Reference Committee heard limited testimony in support of this item. It was noted that despite our AMA’s significant work in this area, there is limited AMA policy addressing prediabetes. Therefore, your Reference Committee recommends that Resolution 434 be adopted

RECOMMENDED FOR ADOPTION AS AMENDED

- (11) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 – INCREASING PUBLIC UMBILICAL CORD BLOOD DONATION IN TRANSPLANT CENTERS

RECOMMENDATION A:

Recommendation in Council on Science and Public Health Report 5 be amended by addition and deletion to read as follows:

Our AMA encourages: (1) the availability of altruistic umbilical cord blood (UCB) donations in all states; and (2) access to public UCB ~~cord~~ banking and the creation of public UCB ~~cord-blood~~ banks to support altruistic UCB ~~cord-blood~~ donation; (3) ~~all-hospitals~~ facilities that provide obstetrics services work to provide access to public (altruistic) umbilical-cord-blood UCB donation, when practicable; (4) that when available, to reduce barriers through education of patients about altruistic umbilical-cord UCB donation; and (5) that ~~hospitals~~ facilities providing obstetrics services and umbilical-cord-blood UCB banking facilities work together to create networks to expand access to and increase efficiency of altruistic umbilical-cord- UCB donations.

2. Our AMA supports federal funding efforts to increase knowledge sharing across umbilical cord blood (UCB) banks and mentoring for centers, physicians, and staff with minimal experience in ~~cord-blood~~ UCB collection.

3. AMA advocates for increased federal and state funding for public umbilical cord blood (UCB) banks to create networks to expand access to and increase efficiency of altruistic umbilical-cord UCB donations in areas lacking the appropriate infrastructure to effectively collect umbilical-cord-blood UCB 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 (UCB) through funding that supports UCB banks to add collection sites where more racial and ethnic minority ~~cord-blood-UCB~~ units can be collected. (Modify Current HOD Policy)

RECOMMENDATION B:

The Council on Science and Public Health Report 5 be filed.

RECOMMENDATION C:

The title of Policy H-370.956 be changed to read as follows:

INCREASING PUBLIC UMBILICAL CORD BLOOD-DONATIONS IN FACILITIES WITH OBSTETRIC SERVICES

HOD ACTION: The title of Policy H-370.956 changed to read as follows:

INCREASING PUBLIC UMBILICAL CORD BLOOD-DONATIONS IN FACILITIES WITH OBSTETRIC SERVICES

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-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)

Testimony on this report was supportive. It was noted that the proposed recommendations aim to improve on current deficits, so patients requiring bone marrow transplants have access to potential life-saving treatments. Additional testimony noted that there are important benefits to the use of cord blood and barriers need to be reduced to have access to altruistic storage and subsequent utilization. An amendment was proffered to clarify that cord blood collection is not a part of routine obstetric care and shouldn’t compromise obstetric or neonatal care. It was further noted that umbilical cord blood donation should not be placed in hospitals without those resources and risk exacerbating obstetric unit closures. Testimony offered also noted that collection of umbilical cord blood is not done in transplant centers and that collection can be done in other facilities and not just hospitals. Your Reference Committee proffered an amendment to remove “transplant centers” and to replace “hospitals” with “facilities” Your Reference Committee elected to use the abbreviation for umbilical cord blood (UCB), as commonly accepted, and used in the report to standardize all language in the policy. Your Reference Committee agrees with this reasoning and therefore has adopted these amendments. Your Reference Committee recommends that the Recommendation in Council on Science and Public Health Report 5 be adopted as amended.

- (12) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 7 – 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

RECOMMENDATION A:

Recommendation 1 in Council on Science and Public Health Report 7 be amended by addition and deletion to read as follows:

1. Our AMA recognizes: (1) the issues with using body mass index (BMI) as a measurement because: (a) of the historical harm of BMI, (b) of the use of BMI for racist exclusion, and (c) BMI cutoffs for underweight, normal, overweight, and obesity are based primarily on health risks in

non-Hispanic White populations. (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, genders, 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. (6) that in some clinical circumstances BMI may have utility and that BMI > 35 should continue to be used for risk stratification. (7) that BMI is a useful tool for population level surveillance of obesity trends due to its ease of use and low risk for application inconsistencies. (8) that BMI is useful as an initial screener for metabolic health risks.

RECOMMENDATION B:

Recommendation 5 in Council on Science and Public Health Report 7 be amended by addition to read as follows:

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 children and 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)

RECOMMENDATION C:

Recommendations in Council on Science and Public Health Report 7 be adopted as amended and the remainder of the report be filed.

RECOMMENDATION D:

The title of Council on Science and Public Health Report 7 be changed to read as follows:

CLARIFYING THE ROLE OF BMI AS A MEASURE IN MEDICINE

HOD ACTION: Recommendations in Council on Science and Public Health Report 7 be adopted as amended with a change in title:

CLARIFYING THE ROLE OF BMI AS A MEASURE IN MEDICINE

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

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 within and between demographic groups at varying levels of adiposity, BMI, body composition, and waist circumference and the importance of monitoring these in all individuals; (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.

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."

Your Reference Committee heard testimony on this report that was mostly supportive. It was noted that the report acknowledges BMI as a clinical tool has shown utility in analyzing certain aspects of health, determining medication dosing requirements, and in its role as a component of research, but there are harms that have resulted from the use of BMI. One amendment was proffered to make clear that our AMA does not necessarily oppose all uses of BMI as a measure, and to suggest that BMI > 35 may continue to be used for risk stratification. Another proffered amendment acknowledged BMI is useful as an initial screener for metabolic health risks. Your Reference Committee agrees with this reasoning, acknowledging that BMI may currently be used as one measure, but more accurate alternative measures

should actively be developed. Testimony in opposition called for referral due to concerns about reimbursement. Testimony also acknowledged that the title of the report is no longer in alignment with the recommendations. Your Reference Committee agrees and therefore recommends that the recommendations in Council on Science and Public Health Report 7 be adopted as amended with a change in title.

- (13) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 8 –
COUNCIL ON SCIENCE AND PUBLIC HEALTH SUNSET REVIEW OF
2013 HOUSE POLICIES

RECOMMENDATION A:

**Recommendation in Council on Science and Public Health Report 8 be
amended by addition to read as follows:**

**That our American Medical Association policies listed in the appendix
to this report be acted upon in the manner indicated, with the exception
of Policies H-440.931 and H-430.988, which should be amended by
addition and deletion to read as follows:**

**H-430.988 Prevention and Control of HIV/AIDS and Tuberculosis in
Correctional Facilities**

**(1) Medical Testing and Care of Individuals who are Incarcerated
~~Inmates Prisoners~~ a) Federal and state correctional systems should
provide comprehensive medical management for all entrants, which
includes voluntary testing for HIV infection and mandatory testing for
tuberculosis followed by appropriate treatment for those infected; b)
Individuals who are incarcerated ~~During incarceration, prisoners~~
~~inmates~~ should be tested for HIV infection as medically indicated or on
their request; c) All individuals who are incarcerated ~~inmates~~ and staff
should be screened for tuberculosis infection and retested at least
annually. If an increase in cases of tuberculosis or HIV infection is noted,
more frequent retesting may be indicated; d) Correctional institutions
should assure that informed consent, counseling, and confidentiality
procedures are in place to protect the patient, when HIV testing is
appropriate; e) During their post-test counseling procedures, HIV-
infected individuals who are incarcerated ~~inmates~~ should be encouraged
to confidentially notify their sexual or needle-sharing partners; and f)
Correctional medical care must, as a minimum, meet the prevailing
standards of care for HIV-infected persons in the outside community at
large. ~~Prisoners Inmates~~ Individuals who are incarcerated should have
access to approved therapeutic drugs and generally employed treatment
strategies. (2) HIV/AIDS Education and Prevention Our AMA: a)
Encourages the inclusion of HIV-prevention information as a regular
part of the education of correctional staff and individuals who are
incarcerated ~~inmate education~~. AIDS education in state and federal
prisons should stress abstinence from drug use and high-risk sexual
practices, as well as the proper use of condoms as one way of decreasing
the spread of HIV; b) Will pursue legislation that encourages state, local,
and federal correctional institutions to make condoms available to
individuals who are incarcerated ~~inmates~~; and c) Urges medical
personnel in correctional institutions to work closely with state and local
health department personnel to control the spread of HIV/AIDS,
tuberculosis, and other serious infectious diseases within and outside
these facilities. (3) Prison-based HIV Partner Notification Program Our
AMA: a) Urges state health departments to take steps to initiate with
state departments of correctional services the development of prison-**

based HIV Partner Notification Programs for individuals who are incarcerated inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

H-440.931 Update on Tuberculosis

It is the policy of the AMA that: (1) All ~~prison~~ individuals who are incarcerated inmates should be tuberculin skin-tested upon arrival and annually thereafter. Those who are positive should be managed as medically appropriate, contact tracing performed, and provisions made for the continued treatment and follow-up of those who are released prior to the completion of their therapy. (2) Staff of both prisons and jails should be tuberculin-tested upon employment and annually thereafter. Those who are positive should be managed as medically appropriate and contact tracing performed. (3) Both public and health care worker education about TB, its transmission, and the necessity for preventive as well as therapeutic treatment should be increased. (4) Current CDC guidelines for the prevention of tuberculosis in congregate settings should be fully implemented. The protection of persons who are immunocompromised needs to be addressed especially by treatment centers housing such persons. (5) While powered air-purification respirators may be useful for the protection of HIV-infected and other immunocompromised health care workers who care for patients with infectious TB, their routine use for the prevention of the nosocomial transmission of TB is uncalled for in health care facilities where CDC guidelines are fully implemented. (6) States should review their TB control laws using current CDC recommendations and recent legal and ethical publications as guidelines. Where necessary to further protect the public health from the disease, existing laws should be modified and/or new ones added.

RECOMMENDATION B:

Recommendation of Council on Science and Public Health Report 8 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendation of Council on Science and Public Health Report 8 adopted as amended and the remainder of the report filed.

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)

Your Reference Committee heard limited testimony on this report. It was noted that there were two policies for which person-first language was not utilized and the appropriate terminology should be “individual who is incarcerated” rather than “inmate.” Your Reference Committee agrees and recommends that Council on Science and Public Health Report 8 be adopted as amended.

- (14) RESOLUTION 402 – ENCOURAGING DISCUSSION OF FAMILY PLANNING COUNSELING AS PART OF RECOMMENDED ROUTINE HEALTH MAINTENANCE

RECOMMENDATION A:

Resolution 402 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with ~~other stakeholders~~ interested parties to encourage discussion of family planning counseling with all individuals with reproductive potential as part of routine health maintenance. (Directive to Take Action)

RECOMMENDATION B:

Resolution 402 be adopted as amended.

HOD ACTION: Resolution 402 adopted as amended.

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)

Your Reference Committee heard testimony mostly in support of this resolution. Physician-initiated conversations surrounding family planning during routine health care maintenance will reduce stigma associated with infertility and promote a greater understanding of a patient’s priorities. The authors submitted an amendment to change the word “stakeholders” to “interested parties,” which is the preferred term. Some concerns were raised about an additional unfunded mandate, while others noted that this is something that should be done anyway and there is no need to codify it in policy. The preponderance of the testimony was in support of the resolution; therefore, the Reference Committee recommends that Resolution 402 be adopted as amended.

- (15) RESOLUTION 403 – DENOUNCING THE USE OF SOLITARY CONFINEMENT IN CORRECTIONAL FACILITIES AND DETENTION CENTERS

RECOMMENDATION A:

Resolution 403 be amended by addition and deletion to read as follows:

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 Solitary Confinement for Incarcerated Persons ~~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, (2) recognize that medical isolation is acceptable 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 medical isolation may be used for as short a time as possible; and (3) recognize that 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 (4) encourage

~~appropriate parties stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities and detention centers.; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~ (Modify Current Policy)

RECOMMENDATION B:

Resolution 403 be adopted as amended.

HOD ACTION: Resolution 403 adopted as amended.

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)

Your Reference Committee heard testimony that was generally supportive of this resolution, but several amendments were proffered for clarity. Testimony from multiple parties attempted to distinguish between solitary confinement, segregation, and medical isolation. It was noted that while solitary confinement should be opposed, the resolution should continue to allow medical isolation for safety concerns which provides facilities appropriate flexibility to make decisions for the safety of the incarcerated population and staff. Your Reference Committee proffers language to clearly delineate between solitary confinement and other types of restrictive housing such as medical isolation and (psychiatric) seclusion. It was suggested to change the word “stakeholders” to “parties,” which is the preferred term. Your Reference Committee recommends that Resolution 403 be adopted as amended.

- (16) RESOLUTION 404 – ADDITIONAL INTERVENTIONS TO PREVENT HUMAN PAPILLOMAVIRUS (HPV) INFECTION AND HPV-ASSOCIATED CANCERS

RECOMMENDATION A:

The first Resolve of Resolution 404 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, by addition to read as follows:

Policy H-440.872: HPV Vaccine and Cervical and Oropharyngeal Cancer Prevention Worldwide

- 1. Our AMA (a) urges physicians and other health care professionals 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~~ parties 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 interested parties to provide make available human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers. (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 404 be amended by addition and deletion to read as follows:

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:

Policy H-55.971: Screening and Treatment for Breast and Cervical Cancer Risk Reduction

1. Our AMA supports programs to screen all ~~women~~ at-risk 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~~ at-risk individuals 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 to ensure

coverage is consistent with current evidence-based guidelines. (Modify Current HOD Policy);

RECOMMENDATION C:

The third Resolve of Resolution 404 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support further research by relevant ~~stakeholders~~ parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening.

RECOMMENDATION D:

Resolution 404 be adopted as amended.

HOD ACTION: Resolution 404 adopted as amended.

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)

Your Reference Committee heard testimony in support of this resolution. Amendments were proffered to remove language that could be misrepresented as a mandate and update the terminology to ensure the use of more inclusive language. Your Reference Committee considered the term “at-risk” to encompass individuals who are high-risk and individuals who have relevant anatomy. Therefore, Your Reference Committee recommends that Resolution 404 be adopted as amended.

- (17) RESOLUTION 405 – AMENDMENT TO AMA POLICY “FIREARMS AND HIGH-RISK INDIVIDUALS H-145.972” TO INCLUDE MEDICAL PROFESSIONALS AS A PARTY WHO CAN PETITION THE COURT

RECOMMENDATION A:

Reaffirm Policy H-145.975, “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” in lieu of the first Resolve.

RECOMMENDATION B:

The second Resolve of Resolution 405 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with relevant ~~stakeholders parties~~ to update medical curricula and physician with training surrounding regarding how to approach conversations with patients and families and to utilize ~~about~~ Extreme Risk Protection Orders/~~Red Flag laws with patients and families~~ (Directive to Take Action); and be it further

RECOMMENDATION C:

The third Resolve of Resolution 405 be amended by addition and deletion to read as follows:

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, local, 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 parties ~~stakeholders,~~ contribute to the inception and development of such petitions;

RECOMMENDATION D:**Resolution 405 be adopted as amended.****HOD ACTION: Resolution 405 adopted as amended.**

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)

Your Reference Committee heard testimony mostly in support of this resolution. There were some concerns noted around the implications for the patient-physician relationship and for possible liability as a result of physicians petitioning for ERPOs. Your Board of Trustees noted that the House of Delegates adopted a directive (Policy H-145.975) calling for the development of an Extreme Risk Protection Order (ERPO) toolkit at I.22 to improve utilization of ERPOs by physicians. It was noted that work on the toolkit is currently underway and will be informed by our AMA’s gun violence task force. Your Reference Committee believes that this current policy and amendments suggested to the second Resolve cover the intent of the first Resolve. Given the rise in firearm deaths in the United States, Your Reference Committee recommends adoption as amended.

- (18) RESOLUTION 407 – ADDRESSING INEQUITY IN ONSITE WASTEWATER TREATMENT

RECOMMENDATION A:

The first Resolve of Resolution 407 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (1) support that federal, state, local, and tribal, governments suspend enforcement of sanitation laws that could result in criminal charges, fines, jail time, and potential property loss for residents who lack the means to purchase functioning septic systems ~~abate individual financial and criminal penalties for insufficient wastewater management, especially those placed on in underserved communities and American Indian~~

~~reservations due to environmental racism and socioeconomic disparities;~~
(New HOD Policy); and be it further

RECOMMENDATION B:

Resolution 407 be amended by the addition of a third Resolve to read as follows:

RESOLVED, That our AMA work with interested parties to reduce and eliminate inadequate wastewater treatment systems. (New HOD Policy)

RECOMMENDATION C:

Resolution 407 be adopted as amended.

HOD ACTION: Resolution 407 adopted as amended

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)

Your Reference Committee heard limited but supportive testimony on Resolution 407. In discussion, your Reference Committee determined that the wording of the Resolution needed to be strengthened and clarified and added amendments to that end, with the Reference Committee particularly noting the need to reduce and eliminate inadequate wastewater treatment systems. Therefore, your Reference Committee recommends that Resolution 407 be adopted as amended.

(19) RESOLUTION 411 – PROTECTING WORKERS DURING CATASTROPHES

RECOMMENDATION A:

The second Resolve of Resolution 411 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate ~~stakeholders parties~~ 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)

RECOMMENDATION B:

Resolution 411 be adopted as amended.

HOD ACTION: Resolution 411 adopted as amended

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)

Your Reference Committee heard mostly positive testimony on Resolution 411. An amendment was proffered that suggested deletion of the clause relating to travel to and from employment, noting that this is not the employer's responsibility and would result in an unreasonable burden. Your Reference Committee agrees with that assessment. Limited testimony in opposition noted that catastrophes are unpredictable, and this will be difficult to regulate. Your Reference Committee wants to clarify that the intent of this resolution is to encourage regulatory bodies to update their policies in this area. Your Reference Committee agrees with the intent and therefore, recommends that Resolution 411 be adopted as amended.

- (20) RESOLUTION 413 – SUPPORTING INTIMATE PARTNER AND SEXUAL VIOLENCE SAFE LEAVE

RECOMMENDATION A:

The second Resolve of Resolution 413 be amended by addition and deletion to read as follows:

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, and Safe~~ 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 and family violence, sexual violence or coercion, and stalking, with appropriate protections for privacy. 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)

RECOMMENDATION B:

Resolution 413 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 413 be changed.

SUPPORTING SAFE LEAVE

HOD ACTION: Resolution 413 be adopted as amended with a change in title:

SUPPORTING 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)

Your Reference Committee heard testimony in support of this resolution. It was noted that individuals who are seeking safety from intimate partner violence or other forms of violence often encounter a significant disruption from their lives, including absence from work and the threat of termination of employment. There was an amendment proffered to ensure protections for patient privacy. Your Reference Committee agreed. However, your Reference Committee also thought that referencing “any violence” was too broad and decided that limiting safe leave to situations such as intimate partner and family violence, sexual violence or coercion, and stalking was more appropriate. Therefore, your Reference Committee recommends that Resolution 413 be adopted as amended.

- (21) RESOLUTION 414 – INCREASED ACCESS TO HIV TREATMENT AND SUPPORTIVE SERVICES IN THE UNSTABLY HOUSED AND HOMELESS POPULATION

RECOMMENDATION A:

The first Resolve of Resolution 414 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support policies that promote stable housing for and encourage retention of the development of regulations and incentives to encourage retention of homeless patients in living with HIV/AIDS treatment programs. (New HOD Policy)

RECOMMENDATION B:

Resolution 414 be adopted as amended.

HOD ACTION: Resolution 414 adopted as amended.

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)

Your Reference Committee heard testimony in support of this resolution. It was noted that the resolution acknowledges that without stable housing, HIV treatment cannot be successful, even with the highly effective medications available today. An amendment was proffered to ensure that the development of regulations and incentives to encourage retention are not misinterpreted to mean that HIV treatment is required for accessing housing. Testimony also noted that linkage to care is important to treatment. Your Reference Committee notes that item 9 in policy H-20.922 explicitly addresses linkage to care. Therefore, your Reference Committee recommends that Resolution 414 be adopted as amended.

- (22) RESOLUTION 415 – ENVIRONMENTAL HEALTH EQUITY IN
FEDERALLY SUBSIDIZED HOUSING

RECOMMENDATION A:

**The first Resolve of Resolution 415 be amended by addition and deletion
to read as follows:**

**RESOLVED, That our American Medical Association acknowledge the
potential adverse health impacts of living in close proximity to a**

Superfund sites or other contaminated lands (New HOD Policy); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 415 be amended by addition to read as follows:

RESOLVED, That our AMA advocate for mandated disclosure of Superfund sites or other contaminated lands proximity to those purchasing, leasing, or currently residing in housing in close proximity to Superfund sites or other contaminated lands (Directive to Take Action); and be it further

RECOMMENDATION C:

Resolution 415 be adopted as amended.

HOD ACTION: Resolution 415 adopted as amended

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 (34) 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)

Your Reference Committee heard limited but unanimously supportive testimony on this resolution. This resolution expands on existing environmental toxins policy. An individual noted that the Reference Committee should examine the definition of EPA Superfund sites as used in this policy, as it may not be the most appropriate term as the risk of exposure to contamination varies significantly across all sites. The Reference Committee discussed this issue and believes the expansion of the resolution to include other contaminated lands addressed this concern. Therefore, your Reference Committee recommends that Resolution 415 be adopted as amended.

- (23) RESOLUTION 417 – TREATING SOCIAL ISOLATION AND LONELINESS AS A SOCIAL DRIVER OF HEALTH

RECOMMENDATION A:

The fourth Resolve of Resolution 417 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with other interested entities to develop ~~toolkits~~ tools and resources to help clinicians identify and address social isolation and loneliness as a social driver of health (Directive to Take Action);

RECOMMENDATION B:

Resolution 417 be adopted as amended.

HOD ACTION: Resolution 417 adopted as amended.

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)

Your Reference Committee heard testimony in support of Resolution 417. This resolution builds on existing AMA policy identifying loneliness as a public health issue with consequences for physical and mental health. This resolution outlines a comprehensive approach toward combating social isolation and loneliness through research, education, and advocacy. An amendment was proffered to the fourth Resolve clause noting that our AMA should include working with other interested parties addressing this issue. Your Reference Committee agrees that there are opportunities for collaboration and recommends that Resolution 417 be adopted as amended.

- (24) RESOLUTION 418 – INCREASING THE AVAILABILITY OF AUTOMATED EXTERNAL DEFIBRILLATORS

RECOMMENDATION A:

Resolution 418 be amended by addition to read as follows:

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 development and 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.

RECOMMENDATION B:

Resolution 418 be adopted as amended.

HOD ACTION: Resolution 418 adopted as amended.

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)

Your Reference Committee heard testimony in support of Resolution 418. Early use of an AED provides the best chance of survival of cardiac arrest. Most of the country experience large disparities with access to AEDs and the public health approaches outlined in this resolution reduce disparity and inequity of out-of-hospital cardiac arrests. It was also noted that targeted placement strategies for AEDs are beneficial for marginalized communities and rural settings. An amendment was offered suggesting that the development of strategies was also needed in this area. Your Reference Committee agrees and recommends that Resolution 418 be adopted as amended.

- (25) RESOLUTION 421 – PRESCRIBING GUIDED PHYSICAL ACTIVITY FOR DEPRESSION AND ANXIETY

RECOMMENDATION A:

Resolution 421 be amended by addition to read as follows:

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 and anxiety symptoms. (Directive to Take Action)

RECOMMENDATION B:

Resolution 421 be adopted as amended.

HOD ACTION: Resolution 421 adopted as amended

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)

Your Reference Committee heard testimony in support of Resolution 421. It was noted that promoting guided physical activity as a therapeutic intervention for depression and anxiety aligns with our AMA's commitment to preventive health measures. A study could help clarify the appropriate exercises and the necessary duration. An amendment was made to align the language of the resolved to the title of the resolution. Therefore, your Reference Committee recommends that Resolution 421 be adopted as amended.

- (26) RESOLUTION 425 – EXAMINING POLICING THROUGH A PUBLIC HEALTH LENS

RECOMMENDATION A:

The first Resolve of Resolution 425 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for research to be conducted that examines the public health consequences

of negative interactions with police, including the impact on civilians and law enforcement professionals, interactions (Directive to Take Action)
RECOMMENDATION B:

The second Resolve of Resolution 425 be **amended by addition and deletion** to read as follows:

RESOLVED, That our AMA advocate for a change to the U.S. Standard Certificate of Death to include a “check box” that would **capture deaths in custody and further categorize the custodial death using cause and manner of death and information from the “How Injury occurred” section of the death certificate, 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)

RECOMMENDATION C:

Resolution 425 be **adopted as amended.**

RECOMMENDATION D:

The **title** of Resolution 425 be **changed** to read as follows:

PROMOTING STANDARDIZATION OF DEATH CERTIFICATION FOR IN-CUSTODY DEATHS

HOD ACTION: Resolution 425 adopted as amended with a change in title:

PROMOTING STANDARDIZATION OF DEATH CERTIFICATION FOR IN-CUSTODY DEATHS

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)

Your Reference Committee heard testimony in support of Resolution 425. It was noted that further research into the public health consequences of negative police interactions is needed. Furthermore, investigating and rendering the cause and manner of death to the community and public health partners is important to help provide the correct epidemiologic data. Amendments were suggested to clarify the second Resolve. Your Reference Committee agrees with these amendments and recommends that Resolution 425 be adopted as amended with a change in title.

(27) **RESOLUTION 427 – MINIMIZING THE INFLUENCE OF SOCIAL MEDIA ON GUN VIOLENCE**

RECOMMENDATION A:

The first Resolve of Resolution 427 be **amended by deletion** to read as follows:

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

RECOMMENDATION B:

Resolution 427 be adopted as amended.

HOD ACTION: Resolution 427 adopted as amended.

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)

Your Reference Committee heard mostly positive testimony in support of this resolution. Your Reference Committee discussed a concern raised regarding the first Resolve and potential conflicts with the First Amendment. Therefore, your Reference Committee deleted “and all others” and believes this will accomplish the intent of the resolution by focusing on social media companies’ terms of service agreements and platform content moderation. As private companies, platforms have the right to exercise editorial judgement. Your Reference Committee notes that our AMA has taken similar positions on medical and public health misinformation on social media, encouraging companies to strengthen their content moderation policies (D-440.915). Therefore, your Reference Committee recommends that Resolution 427 be adopted.

(28) RESOLUTION 428 – MATTRESS SAFETY IN THE HOSPITAL SETTING

RECOMMENDATION A:

Resolution 428 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the accrediting bodies, health care professional organizations, and interested ~~parties 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).

RECOMMENDATION B:

Resolution 428 be adopted as amended.

HOD ACTION: Resolution 428 adopted as amended.

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).

Your Reference Committee heard testimony in support of this resolution. It was noted that not all hospitals are following proper mattress care recommendations from manufacturers and regulatory agencies, which results in an increased spread of infections. Amendments were offered to encourage our AMA to collaborate with other health care

organizations in addressing appropriate care and maintenance measures. Your Reference Committee agrees and recommends that Resolution 428 be adopted as amended.

- (29) RESOLUTION 429 – PROMOTING THE HIGHEST QUALITY OF HEALTHCARE AND OVERSIGHT FOR THOSE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM

RECOMMENDATION A:

The first Resolve of Resolution 429 be amended by addition and deletion to read as follows:

RESOLVED, That the American Medical Association ~~supports~~ encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons ~~positions and other administrators supervising physicians and other clinical staff within its facilities:~~

1. MD or DO, MBSS, or an international equivalent 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, American Indian and Alaska Native 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 (Directive to Take Action).

RECOMMENDATION B:

The second Resolve of Resolution 429 be amended by addition and deletion to read as follows:

RESOLVED, That the AMA ~~initiate a public health campaign or collaborate with appropriate effort to~~ interested parties to promote the highest quality of health care 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).

RECOMMENDATION C:

That Resolution 429 be adopted as amended.

HOD ACTION: Resolution 429 adopted as amended

RESOLVED, That the American Medical Association supports 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 (Directive to Take Action).

RESOLVED, That the 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).

Your Reference Committee heard testimony in support of this resolution. The authors proffered amendments to specify the qualifications were specific to the health services division. Your Reference Committee believes that there may be unintended consequences for extending these qualifications to other administrators supervising physicians and other clinical staff and recommends amendments to remove that language. Testimony was also offered to change “indigenous” to “American Indian and Alaska Native” to be consistent with terminology in existing AMA policy. There were further proffered amendments to the second Resolve to encourage collaboration with interested parties in lieu of an AMA specific campaign to promote the highest quality of health care and oversight for those who are involved in the criminal justice system. Therefore, your Reference Committee recommends that Resolution 429 be adopted as amended.

(30) RESOLUTION 430 – TEENS AND SOCIAL MEDIA

RECOMMENDATION A:

Resolution 430 be amended by deletion to read as follows:

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)

RECOMMENDATION B:

Resolution 430 be adopted as amended.

HOD ACTION: Resolution 430 adopted as amended.

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)

Your Reference Committee heard testimony that was mostly in support of this resolution. There was some opposition to including specific age limits on the use of social media, as that approach does not reflect the evidence and is not the nuanced approach that this topic needs. Your Reference Committee agreed with removing the language related to age limits. Therefore, your Reference Committee recommends that Resolution 430 be adopted as amended.

(31) RESOLUTION 431 – QUALIFIED IMMUNITY REFORM

RECOMMENDATION A:

Resolution 431 be amended by addition of a third Resolve to read as follows:

RESOLVED, That our AMA support research on the impact upon employed physicians in law enforcement and the potential risk for exacerbating the physician workforce shortage within correctional medicine if qualified immunity was eliminated. (Directive to Take Action)

RECOMMENDATION B:

Resolution 431 be adopted as amended.

HOD ACTION: Resolution 431 adopted as amended.

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)

Your Reference Committee heard testimony in support of Resolution 431. It was noted that this resolution is the essential next step for our AMA in promoting accountability, justice, and increased trust in law enforcement. An amendment was proffered to the second Resolve to support research on the potential impact upon employed physicians in law enforcement and the potential risk for exacerbating the physician workforce shortage within correctional medicine if qualified immunity was eliminated. Your Reference Committee agrees that this consideration is important and therefore decided to add a third Resolve. Your Reference Committee recommends that Resolution 431 be adopted as amended.

- (32) RESOLUTION 433 – UPHOLDING SCIENTIFICALLY AND MEDICALLY VALID PRACTICES FOR BLOOD TRANSFUSIONS

RECOMMENDATION A:

The third Resolve of Resolution 433 be amended by addition and deletion as follows:

RESOLVED, That AMA oppose ~~all~~ legislation or policy mandating that blood banks accommodate all directed donor requests. ~~patient requests for blood products from specific donors.~~

RECOMMENDATION B:

Resolution 433 be adopted as amended.

HOD ACTION: Resolution 433 adopted as amended.

RESOLVED, That the American Medical Association support scientifically and medically supported transfusion best practices (New HOD Policy); and be it further

RESOLVED, That AMA discourage patient requests for blood products and components beyond current federal regulations or best-practice guidelines, including requests to exclude products from individuals who have received COVID-19 vaccines (New HOD Policy); and be it further

RESOLVED, That AMA oppose all legislation or policy mandating patient requests for blood products from specific donors. (New HOD Policy)

Your Reference Committee heard testimony in support of this resolution. Testimony noted that blood banks have been receiving specific requests for blood from individuals who have not received a COVID-19 vaccine. Further, testimony noted that some state legislatures have tried to ban blood from individuals who have been vaccinated against COVID-19, a practice which perpetuates vaccine misinformation and is not evidence-based. Furthermore, it is important that we do not create two separate blood supplies. An amendment was proffered by the authors to clarify the third Resolve which is specific to legislation and blood bank accommodation of directed donor requests. Therefore, your Reference Committee recommends that Resolution 433 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (33) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 – SCHOOL RESOURCE OFFICER VIOLENCE DE-ESCALATION TRAINING AND CERTIFICATION
RESOLUTION 408 – SCHOOL-TO-PRISON PIPELINE

RECOMMENDATION A:

The first Recommendation in Council on Science and Public Health Report 4 be amended by addition to read as follows:

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, bullying and cyberbullying 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)

RECOMMENDATION B:

The second Recommendation in Council on Science and Public Health Report 4 be amended by addition and deletion to read as follows:

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; and (5) adequate federal funding to the Bureau of Indian Education to develop and implement SRO programs in consultation with tribal leaders. (New HOD Policy)

RECOMMENDATION C:

The third Recommendation in Council on Science and Public Health Report 4 be amended by addition to read as follows:

3. That our AMA acknowledges that: (1) if a school chooses to utilize SROs, they are part of the school staff at large and their responsibilities should be defined within the context of the school team; and (2)

community-based policing practices are essential for a successful SRO program. (New HOD Policy)

RECOMMENDATION D:

Council on Science and Public Health Report 4 be amended by the addition of a fourth recommendation to read as follows:

4. That our AMA supports: (1) efforts to address physical and mental trauma experienced by children in preschool-12th grade by eliminating disproportionate punitive disciplinary actions and the involvement of law enforcement in student discipline; (2) transitions to restorative approaches that individually address students' medical, social, and educational needs; and (3) ensuring that any law enforcement presence in preschool-12th grade schools focuses on maintaining student and staff safety and not on disciplining students. (New HOD Policy)

RECOMMENDATION E:

Recommendations in Council on Science and Public Health Report 4 be adopted as amended in lieu of Resolution 408.

RECOMMENDATION F:

The Council on Science and Public Health Report 4 be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 4 adopted as amended in lieu of Resolution 408 and the Report filed.

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)

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)

Testimony on this report was supportive. It was noted that this report is inclusive of all parties involved, addresses issues of equity, and encourages support and resources for SRO programs. Testimony in opposition noted that sworn law enforcement should not be present in schools. One amendment was proffered to ensure inclusion of health and education services provided to American Indian and Alaska Native Tribes and Villages. Another amendment was proffered to clarify that the intent is to classify SROs as part of the school-based team, if utilized, and not as a separate entity. An additional proposed amendment wanted to ensure children in preschool were included, noting that trauma and experience with law enforcement happens before kindergarten. Your Reference Committee agrees with this amendment and has ensured inclusion of children in preschool. Your Reference Committee thought that provision 6 of Resolution 408 was not in alignment with the spirit of the remaining provisions and therefore recommends that the alternate recommendations be adopted in lieu of Council on Science and Public Health Report 4 and Resolution 408.

- (34) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 6 – STUDY OF BEST PRACTICES FOR ACUTE CARE OF PATIENTS IN THE CUSTODY OF LAW ENFORCEMENT OR CORRECTIONS
RESOLUTION 432 – CORRECTIONAL MEDICINE

RECOMMENDATION A:

The first Recommendation in Council on Science and Public Health Report 6 be amended by addition and deletion to read as follows:

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 care, palliative care, and substance use care, especially in emergency situations, and (3) if conflict arises during an incarcerated individual's hospitalization that the hospital's bioethics committee should convene to address the issue and not a law enforcement liaison 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)

RECOMMENDATION B:

Council on Science and Public Health Report 6 be amended by the addition of a fourth and fifth recommendation to read as follows:

4. That our AMA supports universal coverage of essential health benefits for all individuals in the custody of law enforcement or corrections and who are incarcerated. (New HOD Policy)

5. That our AMA work with interested parties, including but not limited to, the American College of Emergency Physicians and the American College of Correctional 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)

RECOMMENDATION C:

Recommendations in Council on Science and Public Health Report 6 be adopted as amended lieu of Resolution 432.

RECOMMENDATION D:

The Council on Science and Public Health Report 6 be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 6 adopted as amended lieu of Resolution 432 and Report filed.

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)

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)

Testimony on this report was mostly supportive. It was noted that doctors have a responsibility to provide ethical care to all patients and it is a tenet of medicine to put the patient first. One amendment was proffered to ensure consistency with the standard definitions of palliative care and with AMA policy. An additional amendment was proffered to ensure support of universal coverage of essential health care benefits are provided for all individuals in the custody of law enforcement or corrections and who are incarcerated to ensure adequate access to care. Another proffered amendment ensures that the hospital’s bioethics committee intervenes if conflict arises instead of law enforcement. Another proffered amendment supported inclusion of the American College of Correctional Physicians (ACCP) when developing model federal legislation given their expertise in this field. Your Reference Committee agrees with the amendments and therefore recommends that alternate recommendations be adopted in lieu of Council on Science and Public Health Report 6 and Resolution 432.

- (35) RESOLUTION 401 – METERED DOSE INHALERS AND GREENHOUSE GAS EMISSIONS

RECOMMENDATION:

Alternate Resolution 401 be adopted in lieu of Resolution 401.

RESOLVED, That our AMA advocate to reduce the climate effects of hydrofluorocarbon propellants in metered-dose inhalers and encourage strategies for encouraging the development of alternative inhalers and propellants with equal efficacy and less adverse effect on our climate; and be it further

RESOLVED, That to keep inhaler medications affordable and accessible, our AMA urge FDA to consider metered-dose inhaler propellant substitutions for the purposes of climate protection as drug reclassifications, without new patent or exclusivity privileges, and not allow these substitutions to classify as new drug applications; and be it further

RESOLVED, That our AMA study options for reducing hydrofluorocarbon use in the medical sector.

HOD ACTION: Alternate Resolution 401 adopted in lieu of Resolution 401.

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)

Your Reference Committee heard limited but supportive testimony for Resolution 401. It was noted that there are frequent shortages of breathing treatments that do not use hydrofluorocarbons and that any future actions to discourage the use of these products should address these shortages. Furthermore, alternatives should be readily available, cost effective, and fully covered by health insurance. Your Reference Committee heard that when propellants were previously changed in inhalers, they were determined to be new medications which allowed them to be patented, drastically increasing cost and decreasing accessibility. An alternate resolution was proffered to address these concerns. Your Reference Committee agrees with this alternate language and recommends that alternate Resolution 401 be adopted in lieu of the original resolution.

- (36) RESOLUTION 412 – WASTE RECEPTACLES IN ALL RESTROOM STALLS FOR MENSTRUAL PRODUCT DISPOSAL

RECOMMENDATION A:

Alternate Resolution 412 be adopted in lieu of Resolution 412.

Our AMA will advocate for the inclusion of medical waste receptacles in all restrooms, including male designated stalls, for safe and discreet disposal of medical waste, inclusive of used menstrual products by people who menstruate. (New HOD Policy)

RECOMMENDATION B:

The title of Resolution 412 be changed to read as follows:

Medical Waste Receptacles in All Restroom Stalls

HOD ACTION: Alternate Resolution 412 adopted in lieu of Resolution 412 with a change in title:

Medical Waste Receptacles in All Restroom Stalls

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)

Your Reference Committee heard limited testimony that was unanimously supportive of the intent of the resolution. It was noted that availability of waste receptacles in all restrooms will help individuals who menstruate to evade undue scrutiny and ridicule and will protect their identities and their safety. Offered amendments broadened the resolution to include individuals experiencing other medical conditions that could benefit from waste receptacles in bathrooms without affecting the original intent to protect transgender individuals. Your Reference Committee felt that this broadening of the language resulted in it being outside of the scope of the original policy being amended in Resolution 412. Therefore, your Reference Committee recommends that a new policy be created by alternate Resolution 412 and existing policy H-65.964 remain as is.

(37) RESOLUTION 422 – NATIONAL EMERGENCY FOR CHILDREN

RECOMMENDATION A:

Alternate Resolution 422 be adopted in lieu of Resolution 422.

RESOLVED, That our AMA along with other interested parties advocate that children’s mental health and barriers to mental health care access for children represent a national emergency that requires urgent attention from all interested parties, and be it further

RESOLVED, That our AMA join with other interested parties to advocate for efforts to increase the mental health workforce to address the increasing shortfall in access to appropriate mental health care for children.

RECOMMENDATION B:

The title of Resolution 422 be changed to read as follows:

ADVOCATE FOR A NATIONAL EMERGENCY FOR CHILDREN’S MENTAL HEALTH

HOD ACTION: Alternate Resolution 422 adopted in lieu of Resolution 422 with a change in title:

ADVOCATE FOR A NATIONAL EMERGENCY FOR CHILDREN’S MENTAL HEALTH

RESOLVED, That our American Medical Association declare a national state of emergency in children’s mental health. (New HOD Policy)

Your Reference Committee heard testimony in strong support of the intent of this resolution. One in five children in the country have a mental health issue and access continues to be a problem. It was noted that a national emergency declaration is critical for treating this issue as a crisis and to drive funding and support to address this problem. Alternate Resolved statements were proffered to clarify that our AMA cannot formally declare a national emergency but can work with interested parties toward this goal. Therefore, your Reference Committee recommends that alternate Resolution 422 be adopted.

RECOMMENDED FOR REFERRAL

- (38) RESOLUTION 423 – REDUCING SODIUM INTAKE TO IMPROVE PUBLIC HEALTH

RECOMMENDATION:

Resolution 423 be referred.

HOD ACTION: Resolution 423 referred.

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)

Your Reference Committee heard testimony that was mixed on this resolution. The testimony acknowledged that decreasing sodium intake to improve public health is important. Your Board of Trustees noted that this is an important issue but cautioned that the ask for a patient-centric media campaign has a significant fiscal ask. The Council on Science and Public Health supported referral of this item, noting that their last report on this issue was in 2007. Your Reference Committee believes that studying the best strategies to reduce sodium intake to inform a possible campaign is the most prudent approach toward achieving this goal. Therefore, your Reference Committee recommends that Resolution 423 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

- (39) RESOLUTION 409 – EXPANDING INCLUSION OF DIVERSE MANNEQUINS USED IN CPR AND AED TRAINING

RECOMMENDATION:

Resolution 409 be referred for decision.

HOD ACTION: Resolution 409 referred for decision.

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 Take Action)

Your Reference Committee heard mixed testimony on Resolution 409. It was noted that CPR gives individuals the best chance of survival and it is important to provide anatomically diverse mannequins to prepare individuals for realistic situations. Opposing testimony noted that the original mannequins were created in the likeness of individuals and have historical significance. In addition, they are costly to replace. It was noted that modifications to existing mannequins are currently available and are less costly. It was further noted that consideration for diverse mannequins might be more appropriate when worn mannequins are replaced. Your Reference Committee acknowledges that there are disparities in outcomes of out of hospital cardiac arrest and resuscitation for women and individuals with various body types and that the intent of the resolution is to improve training to alleviate these disparities. Given the mixed testimony, your Reference Committee recommends that Resolution 409 be referred for decision.

RECOMMENDED FOR NOT ADOPTION

- (40) RESOLUTION 426 – ACCURATE ABORTION REPORTING WITH DEMOGRAPHICS BY THE CENTER FOR DISEASE CONTROL

RECOMMENDATION:

Resolution 426 be not adopted.

HOD ACTION: Resolution 426 not adopted.

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. (New HOD Policy)

Your Reference Committee heard overwhelming testimony in strong opposition to this resolution. The CDC took no position, but noted reporting of data to the CDC by jurisdictions is voluntary. Others noted in testimony that this adds unnecessary burdens for physicians and threatens both patient privacy and the physician-patient relationship. Furthermore, it was noted that collecting this data is menacing and harmful, posing an imminent criminal threat to physicians and patients. Therefore, your Reference Committee recommends that Resolution 426 not be adopted.

REPORT OF REFERENCE COMMITTEE E

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Science and Public Health Report 3 - Regulation and Control of Self-Service Labs
2. Resolution 501 – AMA Study of Chemical Castration in Incarceration
3. Resolution 510 - Comparative Effectiveness Research
4. Resolution 511 - Regulation of Phthalates in Adult Personal Sexual Products
5. Resolution 520 - Supporting Access to At-Home Injectable Contraceptives

RECOMMENDED FOR ADOPTION WITH A CHANGE IN TITLE

6. Resolution 509 - Addressing Medical Misinformation Online

RECOMMENDED FOR ADOPTION AS AMENDED

7. Council on Science and Public Health Report 1 - Oppose Scheduling of Gabapentin
8. Council on Science and Public Health Report 2 - Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices
9. Resolution 502 - Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures
10. Resolution 503 - Increasing Diversity in Stem Cell Biobanks and Disease Models
11. Resolution 507 - Recognizing the Burden of Rare Disease
12. Resolution 508 - Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses
13. Resolution 513 - Substance Use History is Medical History
14. Resolution 514 - Adolescent Hallucinogen-Assisted Therapy Policy
15. Resolution 516 - Fasting is Not Required for Lipid Analysis
16. Resolution 517 - Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States
17. Resolution 521 - Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs

RECOMMENDED FOR ADOPTION IN LIEU OF

18. Resolution 505 - Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations
- Resolution 525 - Decriminalizing and Destigmatizing Perinatal Substance Use Treatment
19. Resolution 512 - Wheelchairs on Airplanes
20. Resolution 515 - Resolution to Regulate Kratom and Ban Over-The-Counter Sales
21. Resolution 519 - Rescheduling or Descheduling Testosterone

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

22. Resolution 518 - Defending NIH funding of Animal Model Research From Legal Challenges
23. Resolution 522 - Approval Authority of the FDA

For the purposes of clarity, items marked with double underline or ~~double strikethrough~~ are highlighted in yellow.

RECOMMENDED FOR ADOPTION**(1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 –
REGULATION AND CONTROL OF SELF-SERVICE LABS****RECOMMENDATION:**

That Council on Science and Public Health 3 be adopted and the remainder of the report filed.

HOD ACTION: That Council on Science and Public Health 3 adopted and the remainder of the report 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. 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
 - c. 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)
2. 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)

Your Reference Committee heard limited testimony on CSAPH Report 3. Testimony noted that many companies engage in the practice of direct access testing, sometimes without physician-led teams. Speakers noted that there is a need for changes in the current business model to promote patient safety and access. Additionally, speakers testified that our AMA needs to ensure that direct access tests have oversight and follow relevant rules and regulations. Therefore, your Reference Committee recommends CSAPH Report 3 be adopted.

**(2) RESOLUTION 501 - AMA STUDY OF CHEMICAL CASTRATION
IN INCARCERATION****RECOMMENDATION:**

That Resolution 501 be adopted.

HOD ACTION: That Resolution 501 adopted.

RESOLVED, That our AMA 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)

Your Reference Committee heard testimony in support of Resolution 501 to study chemical castration in incarcerated individuals. Testimony noted the multiple complexities that surround this issue. These complexities include: (1) the disproportionate impact of current practices on Black individuals, LGBTQAI+, and other minoritized groups, (2) requests for the use of chemical castration for sentence reduction, and (3) the potential impact of chemical castration on recidivism. Testimony provided described a need for ethical

guidelines and for our AMA to study this issue for incarcerated people. Therefore, your Reference Committee recommends Resolution 501 be adopted.

(3) RESOLUTION 510 - COMPARATIVE EFFECTIVENESS RESEARCH

RECOMMENDATION:

That Resolution 510 be adopted.

HOD ACTION: That Resolution 510 adopted.

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)

Overall, testimony heard by your Reference Committee was supportive of Resolution 510. Testimony noted that there are financial incentives to study on-patent drugs, but not generics. For example, testimony described how esketamine was approved without comparative effectiveness research over generic ketamine, leading to the more expensive drug being the only FDA-approved drug for certain indications. Speakers noted that by better incorporating comparative effectiveness research into regulatory decisions, these studies could lead to fiscally responsible healthcare. As such, your Reference Committee recommends this Resolution be adopted.

(4) RESOLUTION 511 - REGULATION OF PHTHALATES IN ADULT PERSONAL SEXUAL PRODUCTS

RECOMMENDATION:

That Resolution 511 be adopted.

HOD ACTION: That Resolution 511 adopted.

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)

Your Reference Committee heard limited, but unanimously supportive testimony on this Resolution. Testimony noted that phthalates have commonly been removed from water bottles and children's toys, and adult personal sexual products should be held to a similar standard. Therefore, your Reference Committee recommends that Resolution 511 be adopted.

(5) RESOLUTION 520 - SUPPORTING ACCESS TO AT-HOME INJECTABLE CONTRACEPTIVES

RECOMMENDATION:

That Resolution 520 be adopted.

HOD ACTION: That Resolution 520 adopted.

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)

Testimony for Resolution 520 was unanimously supportive. Speakers noted that the ability of patients to choose their method of contraception and retain bodily autonomy is critical. Testimony also described various barriers patients face, including the inability to take time off work, travel, or arrange childcare to receive injectable contraception. Speakers mentioned several studies demonstrate self-administration of at-home injectable contraceptives is feasible, and the CDC has recommended that these administrations be made available. Therefore, your Reference Committee recommends that Resolution 520 be adopted.

RECOMMENDED FOR ADOPTION WITH A CHANGE IN TITLE

(6) RESOLUTION 509 - ADDRESSING MEDICAL MISINFORMATION ONLINE

RECOMMENDATION:

That Resolution 509 be adopted with a change in title to read as follows:

MEDICAL AND PUBLIC HEALTH MISINFORMATION ONLINE

HOD ACTION: That Resolution 509 adopted with a change in title to read as follows:

MEDICAL AND PUBLIC HEALTH 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.
(Modify Current HOD Policy)

Your Reference Committee heard unanimous testimony in support of this resolution. Testimony noted the extent of this issue beyond social media. Further, that this new policy could continue to work to curb misinformation and potentially build such collaborations in the future. As such, your Reference Committee recommends that this resolution be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (7) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 –
OPPOSE SCHEDULING OF GABAPENTIN

RECOMMENDATION A:

That the third point of the first recommendation in Council on Science and Public Health Report 1 be amended by addition and deletion to read as follows:

3. support the promotion of gabapentinoid-related research and education, particularly the risk of gabapentinoids when taken concomitantly with opioids, and the potential for gabapentinoid withdrawal, including in current clinical practice and undergraduate, graduate and post-graduate education.

RECOMMENDATION B:

That Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: That Council on Science and Public Health Report 1 adopted as amended and the remainder of the report 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-(((1R)-1-((2-methylpropanoyloxy)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)

Your Reference Committee heard testimony that was largely supportive of the Council on Science and Public Health recommendations for opposing the scheduling of gabapentin. Testimony in support recognized the undue barriers in pain management that would arise by scheduling gabapentin along with added administrative burden. An amendment was offered to include the risks associated with gabapentin withdrawal as an important educational effort that your Reference Committee finds appropriate. Opposition to the recommendations of this report centered around the utility of inclusion of gabapentin in prescription drug monitoring databases in states where scheduling of gabapentin is already implemented. However, your Reference Committee was compelled by the supportive testimony over barriers to pain management access and thus, recommends that CSAPH Report 1 be adopted as amended.

(8) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 – IMPROVING RESEARCH STANDARDS, APPROVAL PROCESSES, AND POST-MARKET SURVEILLANCE STANDARDS FOR MEDICAL DEVICES

RECOMMENDATION A:

That the first recommendation of Council on Science and Public Health 2 be amended by deletion to read as follows:

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 when feasible; 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.~~

RECOMMENDATION B:

That Council on Science and Public Health Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: That Council on Science and Public Health Report 2 adopted as amended and the remainder of the report 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)

Testimony was mostly supportive, with an amendment to strike reference to adverse event databases which may receive unverified or unsubstantiated reports. As such, your Reference Committee recommends adoption as amended.

- (9) RESOLUTION 502 - PAIN MANAGEMENT FOR LONG-ACTING REVERSIBLE CONTRACEPTION AND OTHER GYNECOLOGICAL PROCEDURES

RECOMMENDATION A:

That the first resolve of Resolution 502 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA recognizes that disproportionate care the disparity in pain management has been historically present in gynecological procedures and has multifactorial causes, including insurance coverage for pain management which contributes to disparate care in gynecologic 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

RECOMMENDATION B:

That Resolution 502 be amended by addition of a third resolve to read as follows:

Our AMA shall advocate for equitable insurance coverage for the placement of long-acting reversible contraceptives and other gynecological procedures, including associated pain management. (Directive to Take Action)

RECOMMENDATION C:

That Resolution 502 be adopted as amended.

HOD ACTION: That Resolution 502 adopted as amended.

RESOLVED, That our AMA recognizes 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 supports 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)

Your Reference Committee heard overwhelming support for this resolution, particularly related to the multifactorial causes in disparities of pain management in gynecological procedures. An amendment was put forth and supported by several others highlighting the intersection of insurance coverage in this disparity. Your Reference Committee recommends Resolution 502 be adopted as amended.

(10) RESOLUTION 503 - INCREASING DIVERSITY IN STEM CELL BIOBANKS AND DISEASE MODELS

RECOMMENDATION A:

That the second resolve of Resolution 503 be amended by addition to read as follows:

RESOLVED, Our AMA amends Policy H-460.915, “Cloning and Stem Cell Research,”

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 race, ethnicities, and genetic ancestries 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; and be it further

RECOMMENDATION B:

That the third resolve of Resolution 503 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA strongly encourages institutional biobanks to collect ~~racially and ethnically diverse~~ diverse with respect to race, ethnicity, and genetic ancestry, such that future induced pluripotent stem cell disease models better represent the population.

RECOMMENDATION C:

That Resolution 503 be adopted as amended.

HOD ACTION: That Resolution 503 adopted as amended.

RESOLVED, That our AMA encourages 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, Our AMA amends Policy H-460.915, “Cloning and Stem Cell Research,”

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 encourages 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)

Your Reference Committee heard unanimous testimony in support of Resolution 503. An amendment that included an exception for mitochondrial diseases was offered that would have altered the intent of this Resolution and was thus not included. In addition, your Reference Committee proposes an amendment to better align with our AMA policy on language describing race, ethnicity, and genetic ancestry, while maintaining the thrust of the underlying resolution. Your Reference Committee recommends adoption as amended.

(11) RESOLUTION 507 - RECOGNIZING THE BURDEN OF RARE DISEASE

RECOMMENDATION A:

That the second resolve of Resolution 507 be amended by addition to read as follows:

RESOLVED, That our AMA support efforts to increase awareness of patient registries, to improve diagnostic and genetic tests, and to incentivize drug companies and medical device companies to develop novel therapeutics and devices to better understand and treat orphan diseases. (New HOD Policy)

RECOMMENDATION B:

That Resolution 507 be amended by addition of a third resolve to read as follows:

RESOLVED, That our AMA support the study, approval, and coverage of implantable medical devices and therapeutics via FDA Humanitarian Device Exemption for treatment of orphan diseases. (Directive to Take Action)

RECOMMENDATION C:

That Resolution 507 be adopted as amended.

HOD ACTION: Resolution 507 adopted as amended.

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)

Your Reference Committee heard unanimous supportive testimony on this item. Testimony described how our AMA must stand up for patients, especially ones with orphan diseases that are underdiagnosed, undertreated, and underinsured. Speakers noted that patient registries need more support to promote long term monitoring. Amendments were proffered to recognize the treatment of rare diseases goes beyond drugs and encompasses medical devices, which your Reference Committee agreed was appropriate. Therefore, your Reference Committee recommends Resolution 507 be adopted as amended.

(12) RESOLUTION 508 - DEVELOPMENT AND IMPLEMENTATION OF RECOMMENDATIONS FOR RESPONSIBLE MEDIA COVERAGE OF OPIOID OVERDOSES

RECOMMENDATION A:

That Resolution 508 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention, in collaboration with other public and private ~~organizations~~ interested parties, to develop recommendations or best practices for media coverage and portrayal of opioid drug overdoses, including practices to prevent the spread of misinformation. (New HOD Policy)

RECOMMENDATION B:

That Resolution 508 be adopted as amended.

HOD ACTION: Resolution 508 adopted as amended.

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)

Testimony for Resolution 508 was unanimous in support. The testimony noted that media coverage can stigmatize people who use substances. Testimony provided context that media reports often contain outdated and racialized language that is ill-informed, biased, and medically inaccurate. Speakers also noted that our AMA can help drive the public conversation towards evidence-based solutions and reporting on overdoses. Amendments were proffered to include collaboration with interested parties and to add language that includes encouraging practices to prevent the spread of misinformation. An additional, conflicting amendment was received which would move our AMA to a more active role, which was not included, since the current language aligns with similar AMA media policy. Therefore, your Reference Committee recommends that Resolution 508 be adopted as amended.

(13) RESOLUTION 513 - SUBSTANCE USE HISTORY IS MEDICAL HISTORY

RECOMMENDATION A:

That the first resolve of Resolution 513 be amended by addition to read as follows:

RESOLVED, That our American Medical Association support that substance use history, when indicated, 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

RECOMMENDATION B:

That the third resolve of Resolution 513 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with relevant parties stakeholders, including experts in privacy and confidentiality, 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 with protections in place to meet privacy standards and regulations for substance use disorders records and without interfering with existing EHR screening and referral capabilities and functionality. (Directive to Take Action)

RECOMMENDATION C:

That Resolution 513 be adopted as amended.

HOD ACTION: That Resolution 513 adopted as amended.

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)

Your Reference Committee heard mixed testimony for this item. Proponents noted that by increasing the visibility of both individual instances of substance use and substance use disorders, it would encourage providers to be more active and engaged with screening patients for future care. Additionally, they noted that improved charting of substance use and substance use disorders would improve data collection and potential billing. Others voiced concern regarding the privacy of patients, particularly in states with more restrictive laws regarding substance use. Finally, there were additional concerns around the potential stigmatizing effect of conflating individual instances of substance use with a diagnosis of substance use disorder. As such, your Reference Committee recommends adoption of the amended Resolution.

(14) RESOLUTION 514 - ADOLESCENT HALLUCINOGEN-ASSISTED THERAPY POLICY

RECOMMENDATION A:

That Resolution 514 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate against the use of any psychedelics or entactogenic compound (such as psilocybin or MDMA) to treat any psychiatric disorder except those which have received FDA approval or those prescribed in~~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 and entactogenic agents with the same scientific integrity and regulatory standards applied to other promising therapies in medicine. (Directive to Take Action)

RECOMMENDATION B:

That Resolution 514 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 514 be changed to read as follows:

HALLUCINOGEN-ASSISTED THERAPY POLICY

HOD ACTION: That Resolution 514 be adopted as amended with a change in title.

HALLUCINOGEN-ASSISTED THERAPY POLICY

RESOLVED, that our AMA 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)

Your Reference Committee heard mixed testimony regarding Resolution 514. While there was concern for improper and illicit use of these compounds, many noted that they may hold significant opportunity for medical treatments. As such, amendments were proffered to maintain access to medications when they are proven to be safe and effective while pushing back against improper use. The title was modified to remove reference to adolescent populations and reflect the testimony heard seeking protections for all patients. Your Reference Committee recommends adoption of the amended Resolution.

(15) RESOLUTION 516 - FASTING IS NOT REQUIRED FOR LIPID ANALYSIS**RECOMMENDATION A:**

That Resolution 516 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support the development of ~~develop~~ educational programs affirming that fasting is not required for routine screening via lipid analysis. (Directive to Take Action)

Recommendation B:

That Resolution 516 be adopted as amended.

Recommendation C:

That the title of Resolution 516 be changed to read as follows:

FASTING IS NOT REQUIRED FOR ALL LIPID ANALYSIS

HOD ACTION: That Resolution 516 adopted as amended with a change in title:

FASTING IS NOT REQUIRED FOR ALL LIPID ANALYSIS

RESOLVED, That our American Medical Association develop educational programs affirming that fasting is not required for lipid analysis. (Directive to Take Action)

Your Reference Committee heard testimony that was broadly supportive of Resolution 516. Testimony highlighted how fasting lipid testing restricts equitable access to lipid testing, for example, for individuals who struggle to make multiple trips to a laboratory for screening or struggle with fasting requirements. Testimony also noted that our AMA can support other educational efforts on the appropriateness of fasting for lipid testing for different indications. Your Reference Committee recommends adoption as amended.

- (16) RESOLUTION 517 - GENETIC PREDISPOSITION AND HEALTHCARE DISPARITIES, INCLUDING CARDIOVASCULAR DISEASE IN SOUTH ASIANS RESIDING IN THE UNITED STATES

RECOMMENDATION A:

That Resolution 517 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA 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 it further

RESOLVED, that our AMA encourage the development of collaborative partnerships with other organizations, institutions, policymakers, and interested parties ~~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)

RECOMMENDATION B:

That Resolution 517 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 517 be changed to read as follows:

**HEALTHCARE DISPARITIES, INCLUDING
CARDIOVASCULAR DISEASE, IN SOUTH ASIANS RESIDING
IN THE UNITED STATES**

**HOD ACTION: Resolution 517 adopted as amended with a change in
title:**

**HEALTHCARE DISPARITIES, INCLUDING
CARDIOVASCULAR DISEASE, IN SOUTH ASIANS RESIDING
IN THE UNITED STATES**

RESOLVED, that our AMA 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 it 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)

Your Reference Committee heard unanimous support for this resolution as the health disparities in South Asians are under-recognized and under-researched. The Council on Science and Public Health proffered an amendment to reduce the risk of moving back towards racial essentialism by eliminating the language surrounding genetic predisposition, and instead opening research to all potential causes of this inequity. Therefore, your Reference Committee recommends that this Resolution be adopted as amended.

- (17) RESOLUTION 521 - PREVENTING THE ELIMINATION OF CANNABIS FROM OCCUPATIONAL AND MUNICIPAL DRUG TESTING PROGRAMS

RECOMMENDATION A:

That Resolution 521 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support the continued inclusion of cannabis metabolite analysis in relevant 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)

RECOMMENDATION B:

That Resolution 521 be adopted as amended.

HOD ACTION: Resolution 521 adopted as amended.

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)

Your Reference Committee heard limited testimony regarding Resolution 521. It was noted in testimony that while occupational and municipal drug testing is meant to protect others, the use of the word “all” may be burdensome. Particularly due to cannabis metabolite testing limitations and conflicting state and federal regulations, employers may wish to exercise discretion over when and what to test for. Thus, your Reference Committee recommends adoption as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (18) RESOLUTION 505 - IMPROVING ACCESS TO OPIOID ANTAGONISTS FOR VULNERABLE AND UNDERSERVED POPULATIONS
RESOLUTION 525 - DECRIMINALIZING AND DESTIGMATIZING PERINATAL SUBSTANCE USE TREATMENT

RECOMMENDATION:

That Alternate Resolution 505 be adopted in lieu of Resolutions 505 and 525.

DE-STIGMATIZATION AND MANAGEMENT OF SUBSTANCE USE DISORDERS

RESOLVED, That our AMA amend Policy H-420.950, “Substance Use Disorders During Pregnancy” by addition to read as follows:

Our AMA will:

- (1) support brief interventions (such as engaging a patient in a short conversation, providing feedback and advice) and referral for early comprehensive treatment of pregnant individuals with opioid use and opioid use disorder (including naloxone or other overdose reversal medication education and distribution) using a coordinated multidisciplinary approach without criminal sanctions;
- ~~(1)~~ (2) oppose any efforts to imply that a positive verbal substance use screen, a positive toxicology test, or the diagnosis of substance use disorder during pregnancy automatically represents child abuse;
- ~~(2)~~ (3) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy;
- ~~(3)~~ (4) oppose the filing of a child protective services report or the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation;
- ~~(4)~~ (5) 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;
- (6) advocate that state and federal child protection laws be amended so that pregnant people with substance use and substance use disorders are only reported to child welfare agencies when protective concerns are identified by the clinical team, rather than through automatic or mandated reporting of all pregnant people with a positive toxicology test, positive verbal substance use screen,

or diagnosis of a substance use disorder. (Modify Current HOD Policy); and be it further

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 and Other Safe and Effective Overdose Reversal Medications H-95.932

- 1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, 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 and other safe and effective overdose reversal medications delivery.**
- 2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone and other safe and effective overdose reversal medications.**
- 3. Our AMA encourages physicians to co-prescribe naloxone and other safe and effective overdose reversal medications 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 and other safe and effective overdose reversal medications 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 and other safe and effective overdose reversal medications, pursuant to state law.**
- 6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications 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 and other safe and effective overdose reversal medications with the Food and Drug Administration.**
- 8. Our AMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications 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 and other safe and effective overdose reversal medications 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 overdose reversal medications, including naloxone, to help prevent opioid-related overdose, especially in vulnerable populations, including but not limited to**

underserved communities and American Indian reservation populations. (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:

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 safe and effective overdose reversal medications** 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 safe and effective overdose reversal medications** 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); and be it further

RESOLVED, that our AMA study the feasibility, potential methodologies, and implications of early universal screening for substance use and substance use disorders during pregnancy.

HOD ACTION: Alternate Resolution 505 **adopted in lieu** of Resolutions 505 and 525

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)

RESOLVED, That our AMA will advocate that prenatal and peripartum toxicology tests should not be obtained without the informed consent of the birthing parent, if they have capacity to provide consent.

Your Reference Committee heard robust testimony and received multiple amendments on these resolutions. The first and third resolves, related to access to naloxone and the development of adjuncts and alternatives, were unanimously supported. These resolves were clarified with broadening the language to acknowledge the growing market of synthetic agents as well as including other vulnerable populations. Most testimony was heard surrounding the complex issue of screening for substance use in the perinatal period particularly when paired with mandatory reporting requirements to child protective services. Your Reference Committee heard from the abundance of testimony that screening without criminal sanctions would be appropriate to support immediacy of treatment in this critical time as well as maintain the importance of the family bond. An amendment was proffered to study the feasibility and implications for universal screening in perinatal patients. Therefore, your Reference Committee recommends alternate Resolution 505 be adopted in lieu of Resolutions 505 and 525.

(19) RESOLUTION 512 - WHEELCHAIRS ON AIRPLANES

RECOMMENDATION:

That Alternate Resolution 512 be adopted in lieu of Resolution 512.

RESOLVED, That our AMA advocate that Congress, the Federal Aviation Administration, and any other relevant parties make air travel accessibility accommodations for wheelchair users, including but not limited to aircraft modifications to allow wheelchair users to safely travel while remaining in their personal wheelchair. (Directive to Take Action)

HOD ACTION: Alternate Resolution 512 adopted in lieu of Resolution 512.

RESOLVED, That our AMA 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)

Your Reference Committee heard passionate testimony on Resolution 512. There were many who testified of their experiences and challenges traveling with personal wheelchairs, noting damage to their durable

medical equipment, potential for personal harm from transfers required without their wheelchair, or emotional distress caused by missing wheelchairs. While there was additional testimony opposing this resolution with recommendation for referral, others noted pending legislation and a recent consensus study report from the National Academies of Science, Engineering, and Medicine on the feasibility of wheelchair securement on airplanes. As such, your Reference Committee recommends adoption of the Alternate Resolution.

(20) RESOLUTION 515 - RESOLUTION TO REGULATE KRATOM AND BAN OVER-THE-COUNTER SALES

RECOMMENDATION:

That Alternate Resolution 515 be adopted in lieu of Resolution 515.

REGULATION AND STUDY OF KRATOM

RESOLVED, That our American Medical association recommend the following:

- 1. The safety and efficacy of kratom should be determined through research and clinical trials, and subsequently evaluated by the relevant regulatory entities for its appropriateness for over-the-counter sale and potential oversight via the Controlled Substances Act, before it can be marketed, purchased, or prescribed.**
- 2. 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.**
- 3. Individuals who are using kratom only for personal use should not face criminal consequences.**
- 4. 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 (New HOD Policy); and be it further**

RESOLVED, That Policy H-95.934, Kratom and Its Growing Use Within the United States, be rescinded.

HOD ACTION: Alternate Resolution 515 adopted in lieu of Resolution 515.

RESOLVED, that our American Medical Association recommends 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)

Your Reference Committee heard extensive mixed testimony regarding kratom, and whether current AMA policy was appropriate. Testimony was heard supporting the need for further investigation of kratom's medicinal utility and misuse potential before it should be regulated, marketed, sold, or prescribed. Further, for those patients who may already be using kratom for personal use or self-treatment, testimony noted support for coordination of treatment and alignment with current policy related to the decriminalization of substance use. Therefore, your Reference Committee recommends rescinding current conflicting kratom policy and adopting the Alternate Resolution.

Kratom and its Growing Use Within the United States H-95.934

Our AMA supports legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research.

- (21) RESOLUTION 519 - RESCHEDULING OR DESCHEDULING TESTOSTERONE

RECOMMENDATION:

That Alternate Resolution 519 be adopted in lieu of Resolution 519.

DECREASING REGULATORY BARRIERS TO APPROPRIATE TESTOSTERONE PRESCRIBING

RESOLVED, That the AMA ask the FDA to review the available evidence and other data on ~~the abuse potential of~~ testosterone and submit updated recommendations, if warranted, to the DEA, for its consideration of the scheduling of testosterone-containing drug products. (Directive to Take Action); and be it further

RESOLVED, That the AMA, pending FDA review and updated recommendation of scheduling, advocate to expand access to testosterone by decreasing state and health insurer regulatory requirements for testosterone prescribing, including but not limited to PDMP state database reporting, 30-day prescription supply limitations, mail delivery limitations, and telehealth access limitations. (Directive to Take Action)

HOD ACTION: That the first resolve of Alternate Resolution 519 adopted in lieu of Resolution 519 and that the second resolve of Alternate Resolution 519 be referred.

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)

Your Reference Committee heard broadly positive testimony regarding the increase in access to testosterone as related to Resolution 519. The Council on Legislation proffered an amendment to denote the procedure of working with the FDA and other regulatory bodies to evaluate the scheduling of testosterone products for action, which was supported in testimony by others. Additional amendments were also offered which noted the many other ways in which testosterone access is limited unnecessarily. Your Reference Committee clarified the additional amendments to keep consistent with respect for FDA's regulatory authority, while

maintaining ability to advocate for improved access of testosterone. Thus, your Reference Committee recommends adoption of the Alternate Resolution 519.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

- (22) RESOLUTION 518 - DEFENDING NIH FUNDING OF ANIMAL MODEL RESEARCH FROM LEGAL CHALLENGES

RECOMMENDATION:

That policies H-460.979, H-460.957, H-460.932, H-460.953, and H-460.964 be reaffirmed in lieu of Resolution 518.

HOD ACTION: Policies H-460.979, H-460.957, H-460.932, H-460.953, and H-460.964 reaffirmed in lieu of Resolution 518.

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)

Your Reference Committee heard mixed testimony on Resolution 518. Speakers noted that researchers do seek alternatives to animals when reasonable, and that our AMA should not seek to limit animal research since it is often the foundation of medical advances. Additional testimony noted that while there has been little success in finding new drug candidates for treating sepsis, animal models have revealed critical biochemical phenomena which advance our understanding of sepsis. Speakers who testified in opposition sought to reaffirm existing AMA policy, noting that more sophisticated models for human disease are needed, and that the majority of sepsis studies in rodents have failed. Our AMA has existing policy on the ethical standards of using animals in research and would not be barred from briefing a court if deemed appropriate. As such, your Reference Committee recommends that these several policies are reaffirmed in lieu of Resolution 518.

Use of Animals in Research H-460.979

(1) Researchers should include in their protocols a commitment to ethical principles that promote high standards of care and humane treatment of all animals used in research. Further, they should provide animal review committees with sufficient information so that effective review can occur. For their part, institutions should strengthen their animal review committees to provide effective review of all research protocols involving animals. (2) The appropriate and humane use of animals in biomedical research should not be unduly restricted. Local and national efforts to inform the public about the importance of the use of animals in research should be supported. (3) The development of suitable alternatives to the use of animals in research should be encouraged among investigators and supported by government and private organizations. The selection of alternatives ultimately must reside with the research investigator.

Medical Research Involving Animals H-460.957

The AMA urges state and county medical societies to support the appropriate and humane use of animals in research and to help ensure the continued availability of animals for essential medical education and medical research; and reaffirms its support for the appropriate and compassionate use of animals in biomedical research programs.

Increased Public Education Regarding Animal Research H-460.932

Our AMA: (1) supports providing educational materials on the appropriate and compassionate use of animals in biomedical research to students of all grades from kindergarten through grade 12; (2)

encourages physicians to work actively in their communities to introduce educational materials on the appropriate and compassionate use of animals in biomedical research into the curricula of all grades from kindergarten through grade 12; and (3) continues to oppose the use of violence, intimidation, and distortion by the opponents of the appropriate and compassionate use of animals in biomedical research.

Biomedical Research and Animal Activism H-460.953

Our AMA:

(1) supports working through Congress to oppose legislation which inappropriately restricts the choice of scientific animal models used in research and will work with Congress and the USDA to ensure that needs and views of patients and the scientific community are heard during any further consideration of USDA's role in laboratory animal oversight; and

(2) supports laws which make it a federal crime, and similar legislation at state levels to make it a felony, to trespass and/or destroy laboratory areas where biomedical research is conducted.

Use of Animals in Research H-460.964

Our AMA: (1) strongly reemphasizes its support for the humane use of animals in biomedical research in all educational institutions and research facilities; and (2) supports and promotes legislation that is favorable to biomedical research at local, state and national levels and continues to oppose restrictive legislation.

(23) RESOLUTION 522 - APPROVAL AUTHORITY OF THE FDA

RECOMMENDATION:

That policies H-100.948 and H-100.992 be reaffirmed in lieu of Resolution 522.

HOD ACTION: Policies H-100.948 and H-100.992 reaffirmed in lieu of Resolution 522.

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)

Testimony for Resolution 522 was universally supportive of the intent of the resolution but noted existing policies to the same effect. Several speakers noted that in the current political climate, some policies promoted by those without medical training threaten the physician-patient relationship. Speakers noted that our AMA should support the FDA in its continued mission as it has done in the past. However, testimony from the Council on Science and Public Health noted that our AMA has already fulfilled the directive of this resolution and has submitted an amicus brief in support of the FDA and mifepristone access in multiple courts, including the Supreme Court. Amicus briefs have been submitted in (1) Northern District of Texas (Amarillo Division) [Document 91-1, case 2:22-cv-00223-Z], (2) Court of Appeals for the Fifth Circuit [Document 111 of case 23-10362], and (3) the Supreme Court of the United States. Testimony suggested reaffirmation of current policy would prevent disrupting ongoing strong advocacy efforts. Therefore, your Reference Committee recommends reaffirming current AMA policy to continue supporting our AMA's ability to engage in these cases in the courts.

Supporting Access to Mifepristone (Mifeprex) H-100.948

Our AMA will support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies and continue efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone.

FDA H-100.992

1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history

REPORT OF REFERENCE COMMITTEE F

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 4 – AMA 2024 Dues
2. Board of Trustees Report 13 – Delegate Apportionment and Pending Members
3. Board of Trustees Report 18 – Making AMA Meetings Accessible
4. Board of Trustees Report 20 – Surveillance Management Systems for Organized Medicine Policies and Reports
5. Report of the House of Delegates Committee on the Compensation of the Officers
6. Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 – Joint Council Sunset Review of 2013 House Policies
7. Resolution 604 – Speakers Task Force to Review and Modernize the Resolution Process
8. Resolution 610 – NIH Public Access Plan

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

9. Resolution 602 – Supporting the Use of Gender-Neutral Language
10. Resolution 607 – Enabling Sections of the American Medical Association

RECOMMENDED FOR REFERRAL

11. Resolution 603 – Environmental Sustainability of AMA National Meetings
Resolution 608 – Supporting Carbon Offset Programs for Travel for AMA Conferences
12. Resolution 605 – Equity and Justice Initiatives for International Medical Graduates
13. Resolution 606 – AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates
14. Resolution 609 – Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development

RECOMMENDED FOR NOT ADOPTION

15. Resolution 601 – Solicitation Using the AMA Brand

RECOMMENDED FOR FILING

16. Board of Trustees Report 1 – Annual Report

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 4 - AMA 2024 DUES

RECOMMENDATION:

Recommendation in Board of Trustees Report 4 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 4 adopted and the remainder of the Report filed.

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 Training	\$45
Medical Students	\$20

(Directive to Take Action)

Testimony was limited in response to Board of Trustees Report 4, but included a request that future reports be segmented to reflect the number of dues paid at full and discounted rates.

- (2) BOARD OF TRUSTEES REPORT 13 - DELEGATE APPORTIONMENT AND PENDING MEMBERS

RECOMMENDATION:

Recommendation in Board of Trustees Report 13 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 13 adopted and the remainder of the Report filed.

The 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.

Testimony provided by the Board of Trustees reflected that the results from the trial period did not provide evidence that pending members increased membership or benefited constituent societies. The trial also revealed some potential downsides, such as adding additional cost to member tracking and unnecessarily complicating the apportionment process. Thus, the Board of Trustees is recommending that the practice of counting pending members for apportionment purposes not be continued and our AMA return to the practice of counting actual members for apportionment.

There was confusion in the testimony opposing Board of Trustees Report 13 regarding the definition of pending member, which lead your Reference Committee to believe that the recommendation of the Board of Trustees to end the practice of counting pending members is a sound recommendation.

Your reference committee recommends Board of Trustees Report 13 be adopted.

- (3) BOARD OF TRUSTEES REPORT 18 - MAKING AMA MEETINGS ACCESSIBLE

RECOMMENDATION:

Recommendation in Board of Trustees Report 18 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 18 adopted and the remainder of the Report filed.

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.

Board of Trustees Report 18 outlines accommodations to make AMA meetings accessible for members and invited attendees with disabilities. Testimony indicated that the Board report did not provide a plan for members who cannot physically attend AMA meetings, and requested a report back outlining options for those members.

It was shared that a report addressing Resolution 622-A-22, HOD Modernization, will be presented for consideration during the 2023 Interim Meeting. This report will address concerns associated with members that cannot physically attend in person, regardless of the reason.

Therefore, your Reference Committee recommends that Board of Trustees Report 18 be adopted.

- (4) BOARD OF TRUSTEES REPORT 20 - SURVEILLANCE MANAGEMENT SYSTEM FOR ORGANIZED MEDICINE POLICIES AND REPORTS

RECOMMENDATION:

Recommendations in Board of Trustees Report 20 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 20 adopted and the remainder of the Report filed.

The Board of Trustees 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)

Board of Trustees Report 20 outlines efforts to learn more about user experiences with resources such as PolicyFinder, Council Report Finder and AMA Archives. The report noted that these findings will be used to inform opportunities for enhanced tracking.

Limited testimony noted concerns over the scope and process for implementing Recommendation 2, which calls for the AMA to continue investment in critical information technology and other appropriate infrastructure that allows for the tracking of past resolutions, existing policy and supporting materials.

Given the ongoing work of the AMA on this issue, your Reference Committee recommends adoption of Board of Trustees Report 20.

(5) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Recommendation in the Report of the House of Delegates Committee on the Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in the Report of the House of Delegates Committee on the Compensation of the Officers adopted and the remainder of the Report filed.

The House of Delegates Committee on the Compensation of the Officers recommends that the following recommendations be adopted:

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.

The Committee on Compensation testified that there are no changes to the Officers' compensation for July 1, 2023 through June 30, 2024.

Your Reference Committee recommends that the recommendations in the Report of the House Delegates Committee on Compensation of the Officers be adopted, and the remainder be filed.

(6) COUNCIL ON CONSTITUTION AND BYLAWS/COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - JOINT COUNCIL SUNSET REVIEW OF 2013 HOUSE POLICIES

RECOMMENDATION:

Recommendation in the Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in the Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

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.

Beyond the introduction of the Council on Constitution and Bylaws and the Council on Long Range Planning and Development Report 1, no further testimony was provided.

Your Reference Committee wishes to extend its appreciation to the councils for their collaborative effort and thorough work product.

- (7) RESOLUTION 604 - SPEAKERS TASK FORCE TO REVIEW AND MODERNIZE THE RESOLUTION PROCESS

RECOMMENDATION:

Resolution 604 be adopted.

HOD ACTION: Resolution 604 adopted.

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)

Testimony was largely supportive of Resolution 604. According to testimony, the AMA should evaluate and identify options to streamline various aspects of the resolution process. Although testimony noted that integrating virtual options could support efficiency, it was shared that the option to hold deliberations in-person should be preserved.

While there were requests for referral to allow exploration of options to enhance resolution processes, your Reference Committee believes this is a House of Delegates issue that should be handled through the Speaker's Taskforce. Therefore, your Reference Committee recommends adoption.

- (8) RESOLUTION 610 - NIH PUBLIC ACCESS PLAN

RECOMMENDATION:

Resolution 610 be adopted.

HOD ACTION: Resolution 610 adopted.

RESOLVED, That our American Medical Association work with publishing and professional organizations, and work with Congress, to raise awareness of possible adverse consequences of the proposed National Institutes of Health Public Access Plan and to mitigate such consequences to ensure continued equitable access to quality clinical research. (Directive to Take Action)

Your Reference Committee heard an abundance of testimony in support of Resolution 610.

Testimony stressed the potential unintended consequences of the National Institutes of Health Public Access Plan regarding equity, quality, scientific record oversight, and financial sustainability. Supporters of this resolution also explained the importance of working collaboratively with stakeholders to devise solutions that balance equity, accessibility, and sustainability to ensure a thriving and robust scientific community.

Your Reference Committee recommends Resolution 610 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (9) RESOLUTION 602 - SUPPORTING THE USE OF GENDER-NEUTRAL LANGUAGE

RECOMMENDATION A:

Resolution 602 be amended by addition and deletion to read as follows:

HOD ACTION: Resolution 602 amended by addition and deletion to read as follows:

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~~ prospectively amend all current AMA policy, where appropriate, to include gender-neutral language by way of the reaffirmation and sunset processes, (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)

RECOMMENDATION B:

Resolution 602 be adopted as amended.

HOD ACTION: Resolution 602 adopted as amended.

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)

Your Reference Committee received generally supportive testimony in response to Resolution 602; however, there were concerns expressed about use of AMA resources to retrospectively revise all relevant policies to utilize gender-neutral language in place of gendered language where such text inappropriately appears. Alternatively, it was proffered that current AMA policy be amended gradually by way of the reaffirmation and sunset processes.

- (10) RESOLUTION 607 - ENABLING SECTIONS OF THE AMERICAN MEDICAL ASSOCIATION

RECOMMENDATION A:

Resolution 607 be amended by addition and deletion to read as follows:

HOD ACTION: Resolution 607 amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association Sections will be given an option to meet ~~meetings be held~~ officially over no less than two calendar days in anticipation of general House of Delegates meetings ~~subject to space limitations and budget constraints unless otherwise determined by a given individual Section unless otherwise determined~~ by a given individual Section. (Directive to Take Action)

RECOMMENDATION B:

Resolution 607 be adopted as amended.

HOD ACTION: Resolution 607 adopted as amended.

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)

Your Reference Committee heard mixed testimony in response to Resolution 607. Concerns noted that sections that need additional time to meet should be given the option without requiring all sections to move to a two-day meeting. It was further noted that an additional day for sections meeting could present funding and staffing concerns. In addition, space limitations, particularly at already contracted venues, may present challenges.

During testimony, clarification was offered that neither the Board of Trustees nor the House of Delegates has restricted the length of meetings for sections.

Your Reference Committee proffered an amendment to address concerns related to determining the length of the Section meetings. Therefore, your Reference Committee recommends that Resolution 607 be adopted as amended.

RECOMMENDED FOR REFERRAL

- (11) RESOLUTION 603 - ENVIRONMENTAL SUSTAINABILITY OF AMA NATIONAL MEETINGS
RESOLUTION 608 - SUPPORTING CARBON OFFSET PROGRAMS FOR TRAVEL FOR AMA CONFERENCES

RECOMMENDATION:

Resolutions 603 and 608 be referred.

HOD ACTION: Resolutions 603 and 608 referred.

Resolution 603:

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)

Resolution 608:

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)

Your Reference Committee received overwhelming testimony favoring referral of both Resolutions 603 and 608. Testimony suggested that our AMA needs to lead the profession by example, but it was acknowledged that a fully vetted strategic plan for addressing environmental sustainability needs to be developed with attention to fiscal impact.

(12) RESOLUTION 605 - INTERNATIONAL MEDICAL GRADUATES SECTION

RECOMMENDATION:

Resolution 605 be referred.

HOD ACTION: Resolution 605 referred.

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)

Testimony received in response to Resolution 605 was supportive of the intent, noting that International Medical Graduates face considerable discrimination and have specific professional issues of concern.

Although an alternative resolution was proffered, there were questions about the best mechanism for collaboration and engagement with the Center for Health Equity.

Your Reference Committee would like to highlight that the AMA's strategic plan to embed racial justice and advance health equity will be updated later this year. Future updates could potentially incorporate issues affecting International Medical Graduates. Therefore, your Reference Committee recommends that Resolution 605 be referred to achieve this purpose.

- (13) RESOLUTION 606 - AMA REIMBURSEMENT OF NECESSARY HOD BUSINESS MEETING EXPENSES FOR DELEGATES AND ALTERNATE DELEGATES

RECOMMENDATION:

Resolution 606 be referred.

HOD ACTION: Resolution 606 referred for report back at I-23.

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)

Your Reference Committee heard mixed testimony in response to Resolution 606. Those favoring adoption indicated that a number of state and medical specialty society delegations have difficulty funding representatives due to continued membership declines. Several representatives indicated they incur personal expense to attend our AMA House of Delegates meetings. In addition, medical students and residents expressed issues with obtaining funding and are seeking inclusion in the development of an AMA reimbursement policy. Those opposed testified that there is insufficient information to make an informed decision.

The Board of Trustees indicated that due to the complexity of the issue, referral of Resolution 606 would be welcomed. Specific issues of concern, included:

- The estimated \$8.1 million dollar fiscal note would be the minimum annual operating expense.
- Policy does not permit AMA to use reserves for ongoing annual operating expenses, which means our AMA would need to find expense reductions in other parts of the budget.
- Although our AMA has experienced exceptional fiscal success over the last several years due to a reduction in expenses during the pandemic, once the Association returns to full employment and regular operations, our AMA will be back to the normal budgeted levels.
- Expanding the individuals whose expenses are paid for involve tax and legal implications that need to be fully vetted.
- An assessment of the impact on our AMA brand and potential effects on advocacy activity needs to be undertaken.

Your Reference Committee found the Board of Trustees testimony to be most compelling given their fiduciary responsibility for our AMA. Therefore, your Reference Committee believes referral with report

back at the 2024 Annual Meeting will allow sufficient time to identify and fully assess the impact on our AMA.

- (14) RESOLUTION 609 - ENCOURAGING COLLABORATION BETWEEN PHYSICIANS AND INDUSTRY IN AI (AUGMENTED INTELLIGENCE) DEVELOPMENT

RECOMMENDATION:

Resolution 609 be referred.

HOD ACTION: Resolution 609 referred.

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)

The majority of testimony in response to Resolution 609 was supportive of referral for study. Testimony stressed the complexity of the issue, and the importance of ensuring physicians have representation in the evolving industry of augmented intelligence. There was support for the intent of the resolution, but some testimony indicated the resolution was too prescriptive as written.

Your Reference Committee recommends that Resolution 609 be referred for report back.

**~~RECOMMENDED FOR NOT ADOPTION~~
REFERRED FOR DECISION**

- (15) RESOLUTION 601 - SOLICITATION USING THE AMA BRAND

RECOMMENDATION:

Resolution 601 not be adopted.

HOD ACTION: Resolution 601 referred for decision.

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)

Your Reference Committee received mixed testimony in response to Resolution 601. Those who testified in support expressed concern about third-party advertisements tarnishing our AMA's reputation, and the inconveniences and frustration of receiving advertisements that are not of interest.

The Board of Trustees testimony spoke in opposition of this resolution and explained that: (a) reducing the frequency of direct mail would reduce customer base and negatively impact revenue; (b) a quantitative study could cost in excess of \$200K and is unlikely to yield definitive actionable results; (c) all physicians and medical students already have the option to opt-out of marketing communications, and that these options are outlined in our AMA's Data Distribution and Privacy Policy; (d) our AMA is in the process of enhancing and streamlining the options offered to control private data usage.

For these reasons, your Reference Committee recommends Resolution 601 not be adopted.

RECOMMENDED FOR FILING**(16) BOARD OF TRUSTEES REPORT 1 - ANNUAL REPORT****RECOMMENDATION:**

Board of Trustees Report 1 be filed.

HOD ACTION: Board of Trustees Report 1 filed.

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.

Beyond the introduction of Board of Trustees Report 1, your reference committee received no further testimony.

Your reference committee recommends that the Board of Trustees Report 1 be filed.

REPORT OF REFERENCE COMMITTEE G

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 14 – Advocacy of Private Practice Options for Health Care Operations in Large Corporations
2. Council on Medical Service Report 01 – Council on Medical Service Sunset Review of 2013 House Policies
3. Resolution 701 – Reconsideration of the Birthday Rule
4. Resolution 703 – Tribal Health Program Electronic Health Record Modernization
5. Resolution 714 – Improving Hospice Program Integrity
6. Resolution 716 – Transparency and Accountability of Hospitals and Hospital Systems
7. Resolution 724 – Rural Hospital Payment Models

RECOMMENDED FOR ADOPTION AS AMENDED

8. Council on Medical Service Report 05 – Prescription Drug Dispensing Policies
9. Council on Medical Service Report 08 – Impact of Integration and Consolidation on Patients and Physicians
10. Council on Medical Service Report 09 – Federally Qualified Health Centers and Rural Health Care
11. Resolution 702 – Providing Reduced Parking for Patients
12. Resolution 704 – Interrupted Patient Sleep
13. Resolution 706 – Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis
14. Resolution 709 – Hospital Bans on Trial of Labor After Cesarean
15. Resolution 713 – Redesigning the Medicare Hospice Benefit
16. Resolution 719 – Care Partner Access to Medical Records
17. Resolution 721 – Use of Artificial Intelligence for Prior Authorization
18. Resolution 726 – Proper Use of Overseas Virtual Assistants in Medical Practice
19. Resolution 727 – Health System Consolidation

RECOMMENDED FOR ADOPTION IN LIEU OF

20. Resolution 707 – Expediting Repairs for Power and Manual Wheelchairs
21. Resolution 711 – Doctors’ Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs
22. Resolution 718 – Insurance Coverage of FDA Approved Medications and Devices
23. Resolution 720 – Prior Authorization Costs, AMA Update to CMS
24. Resolution 723 – Vertical Consolidation in Health Care – Markets or Monopolies

RECOMMENDED FOR REFERRAL

25. Resolution 710 – Protect Patients with Medical Debt Burden
- Resolution 712 – Medical Bankruptcy – A Unique Feature in the USA
26. Resolution 715 – Published Metrics for Hospitals and Hospital Systems
27. Resolution 722 – Expanding Protections of End-of-Life Care
28. Resolution 725 – The Economics of Prior Authorization

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

29. Resolution 705 – Aging and Dementia Friendly Health Systems
30. Resolution 728 – Discharge Consolidated Clinical Document Architecture (C-CDA) Minimum Data Set Content and Order Priority

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 14 - ADVOCACY OF PRIVATE PRACTICE OPTIONS FOR HEALTHCARE OPERATIONS IN LARGE CORPORATIONS

RECOMMENDATION:

The recommendations in Board of Trustees Report 14 be adopted and the remainder of the report be filed.

HOD ACTION:

The recommendations in Board of Trustees Report 14 adopted and the remainder of the report filed.

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)

Your Reference Committee heard unanimous testimony in support of Board of Trustees Report 14. Testimony noted that private practices can be useful to corporate entities without being acquired or owned and further noted that this pilot program is welcomed. Your Reference Committee recommends that the recommendations in Board of Trustees Report 14 be adopted and the remainder of the report be filed.

- (2) COUNCIL ON MEDICAL SERVICE REPORT 01 – COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2013 HOUSE POLICIES

RECOMMENDATION:

The recommendations in Council on Medical Service Report 01 be adopted and the remainder of the report be filed.

HOD ACTION:

The recommendations in Council on Medical Service Report 01 adopted and the remainder of the report filed.

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 the report be filed.

Your Reference Committee heard limited supportive testimony on Council on Medical Service Report 01. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 01 be adopted and filed.

(3) RESOLUTION 701 - RECONSIDERATION OF THE BIRTHDAY RULE

RECOMMENDATION:

Resolution 701 be adopted.

HOD ACTION:

Resolution 701 adopted.

RESOLVED, That our American Medical Association (AMA) 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 insurances 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)

Testimony on Resolution 701 was unanimously supportive. Speakers discussed the importance for the AMA to support parent's choice for their child's insurance and the necessity for coordination of insurance benefits. Therefore, your Reference Committee recommends the adoption of Resolution 701.

- (4) RESOLUTION 703 - TRIBAL HEALTH PROGRAM ELECTRONIC HEALTH RECORD MODERNIZATION

RECOMMENDATION:

Resolution 703 be adopted.

HOD ACTION:

Resolution 703 adopted.

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)

Your Reference Committee heard testimony that supporting the modernization and maintenance of electronic health records as important to patient care. Tribal and Urban Indian Health Programs may not have received federal funding for EHR modernization in the past and operate with limited ability to communicate with other health care record management systems. For example, the system has difficulty communicating with immunization information systems. Your Reference Committee also heard testimony from the Council on Medical Service stating that past influxes of federal funding for EHRs have at times caused patient harm and increased burden on physicians, and therefore, they were in support of the resolution. Your Reference Committee recommends Resolution 703 be adopted.

- (5) RESOLUTION 714 - IMPROVING HOSPICE PROGRAM INTEGRITY

RECOMMENDATION:

Resolution 714 be adopted.

HOD ACTION:

Resolution 714 adopted.

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)

Your Reference Committee heard unanimously supportive testimony in support of Resolution 714. It is important for the AMA to call on the Centers for Medicare and Medicaid Services to refocus their efforts to combat fraud and abuse with the proliferation of hospice programs. Testimony noted that allowing fraud and abuse to continue is not only harmful for patients, but also harms hospice programs and facilities operating with integrity. Your Reference Committee recommends Resolution 714 be adopted.

(6) RESOLUTION 716 - TRANSPARENCY AND ACCOUNTABILITY OF HOSPITALS AND HOSPITAL SYSTEMS

RECOMMENDATION:

Resolution 716 be adopted.

HOD ACTION:

Resolution 716 adopted.

RESOLVED, That our American Medical Association identify options for developing and implementing processes – including increased transparency of physicians complaints made to the Equal Employment Opportunity Commission and The Joint Commission – for tracking and monitoring physician complaints against hospitals and hospital 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)

Testimony on Resolution 716 was primarily supportive. Speakers discussed the importance of ensuring that complaints are not only filed, but that they are investigated and that entities are penalized when a complaint be substantiated. Testimony also indicated how vital information on workplace complaints is for physicians who are considering new employment. The Council on Legislation testified that AMA addresses the concern of this resolution and suggested reaffirmation. However, due to significant and compelling testimony, your Reference Committee recommends that Resolution 716 be adopted.

(7) RESOLUTION 724 - RURAL HOSPITAL PAYMENT MODELS

RECOMMENDATION:

Resolution 724 be adopted.

HOD ACTION:

Resolution 724 adopted.

RESOLVED, That our American Medical Association urgently collaborate with appropriate stakeholders to protect health care delivery in underserved, rural communities and work to preserve the economic viability of rural sole community hospitals which are the primary lines of healthcare defense in rural America (Directive to Take Action); and be it further

RESOLVED, That our AMA study alternative rural hospital payment models for feasibility, including a patient-centered payment model and standby capacity payments for essential services, in helping preserve rural community hospitals financially and preserving access to care for patients (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirms policies H-465.979, H-200.972, H-465.990, and H-465.994. (Reaffirm HOD Policy)

Testimony on Resolution 724 was unanimously supportive. Speakers indicated the necessity of guaranteeing that rural hospitals are adequately funded to ensure they remain open to serve their communities. Testimony also discussed the importance of adequate payment to not only ensure that rural hospitals remain open, but that they are able to provide important services. Due to the overwhelming and compelling support for this resolution, your Reference Committee recommends that Resolution 724 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (8) COUNCIL ON MEDICAL SERVICE REPORT 05 - PRESCRIPTION DRUG DISPENSING POLICIES

RECOMMENDATION A:

Council on Medical Service Report 05 be amended by addition of a new Recommendation.

6. That our AMA support the development, implementation and/or use of electronic or other means of communication to provide cost and coverage information of various prescribing quantities at the point of care allowing physicians to make the best decisions with their patients regarding prescribed medication quantities. (New HOD Policy)

RECOMMENDATION B:

The recommendations in Council on Medical Service Report 05 be adopted as amended and the remainder of the report be filed.

HOD ACTION:

The recommendations in Council on Medical Service Report 05 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 237-A-22, and that the remainder of the report be filed:

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 states 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 AMA 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)

The testimony on Council on Medical Service Report 05 was unanimously supportive with one proffered amendment. Testimony noted the importance of patients and physicians’ ability to collaboratively decide the appropriate quantity of medication dispensed to a patient. Testimony was offered that cautioned the overreach of Pharmacy Benefit Managers (PBMs) into Electronic Health Records. Testimony explained the importance of ensuring that PBMs are not involved in the decision regarding the quantity of medication dispensed. Therefore, your Reference Committee recommends that CMS Report 05 be adopted as amended and the remainder of the report be filed.

- (9) COUNCIL ON MEDICAL SERVICE REPORT 08 - IMPACT OF INTEGRATION AND CONSOLIDATION ON PATIENT AND PHYSICIANS

RECOMMENDATION A:

The sixth recommendation in Council on Medical Service Report 08 be deleted.

~~6. That our AMA rescind Policy D-215.984. (Rescind HOD Policy)~~

RECOMMENDATION B:

Council on Medical Service Report 08 be adopted as amended and the remainder of the report be filed.

HOD ACTION:

Council on Medical Service Report 08 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following recommendations be adopted, and the remainder of the report be filed:

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)

Your Reference Committee heard testimony that was generally supportive of Council on Medical Service Report 08. Testimony supported the deletion of the sixth recommendation of the report to encourage continued study on the topic of consolidation by the Council.

Although testimony was heard in conjunction with Resolution 723 and Resolution 727, your Reference Committee considered these items individually when preparing our recommendations.

Your Reference Committee notes that testimony was overwhelmingly in favor of the AMA continuing work on the issues of consolidation as well as mergers and acquisitions. Testimony indicated that the House of Delegates looks forward to additional reports from the Council on Medical Service regarding this issue.

Your Reference Committee recommends that the recommendations in Council on Medical Service Report 08 be adopted as amended and the remainder of the report be filed.

Health System Consolidation D-215.984

Our AMA will: (1) study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation; and (2) regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than the 2023 Annual Meeting.

- (10) COUNCIL ON MEDICAL SERVICE REPORT 09 - FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CARE

RECOMMENDATION A:

Council on Medical Service Report 09 be amended by addition of a new Recommendation 3 with subsequent renumbering.

- 3. That our AMA advocate for regular updates to the Medicaid FQHC Prospective Payment System that at least keep pace with inflation. (New HOD Policy)**

RECOMMENDATION B:

The recommendations in Council on Medical Service Report 09 be adopted as amended and the remainder of the report be filed.

HOD ACTION:

The recommendations in Council on Medical Service Report 09 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

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)

Testimony on CMS Report 09 was unanimously supportive. Speakers expressed the importance of supporting physicians practicing in rural areas and the importance of Federally Qualified Health Centers (FQHCs) to support these and other underserved communities. Testimony indicated that FQHCs enable physicians to provide healthcare to communities that are severely underserved and are vital for public health efforts. Therefore your Reference Committee recommends that the recommendation in CMS Report 09 be adopted as amended and the remainder of the report be filed.

- (11) RESOLUTION 702 - PROVIDING REDUCED PARKING FOR PATIENTS

RECOMMENDATION A:

Resolution 702 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with relevant stakeholders to recognize parking fees as a barrier to patient care and encourage mechanisms to reduce ing-parking costs ~~for patients and trainees~~.

RECOMMENDATION B:**Resolution 702 be adopted as amended.****HOD ACTION:****Resolution 702 adopted as amended.**

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)

Testimony was supportive of the spirit of Resolution 702. There was concern noted that the resolution mentioned fees for trainee parking when this was not noted in the title or the whereas clauses. Further testimony encouraged broadening this resolution to make it inclusive of family members, volunteers, and others who may be burdened with high parking fees. Subsequent testimony supported these amendments. There was mention of validating parking as opposed to reducing fees, but your Reference Committee did not find this compelling after testimony that mentioned the burden this would place on private practices.

The amendments proffered in this resolution are consistent with the research presented in the whereas clauses. Your Reference Committee recognizes that this is an access to care issue and, therefore, recommends Resolution 702 be adopted as amended.

(12) RESOLUTION 704 - INTERRUPTED PATIENT SLEEP

RECOMMENDATION A:**The first Resolve of Resolution 704 be amended by deletion to read as follows:**

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

RECOMMENDATION B:**The second Resolve of Resolution 704 be amended by deletion to read as follows:**

RESOLVED, That our AMA support efforts to improve quality, duration, and timing of inpatient sleep. (New HOD Policy)

RECOMMENDATION C:**Resolution 704 be adopted as amended.****HOD ACTION:****Resolution 704 adopted as amended.**

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)

Testimony on Resolution 704 was supportive of the spirit of the resolution. There was agreement that optimizing sleep for patients in the hospital is beneficial and supports timely healing and well-being.

We heard compelling testimony that this needs to apply to all patients, not just inpatients. We recommend amendments to address this and make the resolution more generalizable to all patients.

Your Reference Committee has chosen to keep the language of this resolution broad. Given the complexities of different clinical scenarios it is preferable to give flexibility to local governance in the clinical setting and the language presented here accomplishes this. Based on testimony heard, we were cautious about being overly prescriptive in the amended language. Therefore, your Reference Committee recommends Resolution 704 be adopted as amended.

- (13) RESOLUTION 706 - REVISION OF H-185.921, REMOVAL OF AMA SUPPORT FOR APPLIED BEHAVIOR ANALYSIS

RECOMMENDATION A:

The third Resolve of Resolution 706 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend Policy H-185.921 to read as follows:

Standardizing Coverage of Evidence-Based Treatments for Neurodivergent Individuals ~~Applied Behavioral Analysts Therapy for Persons with Autism Spectrum Disorder~~, H-185.921

Our AMA support coverage and reimbursement for evidence-based treatments and treatment of services for neurodivergent individuals, including Autism Spectrum Disorder including, but not limited to, Applied Behavior Analysis Therapy. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 706 be adopted as amended.

RECOMMENDATION C:

The Title of Resolution 706 be changed.

CARING FOR NEURODIVERGENT PATIENTS

HOD ACTION:

Resolution 706 adopted as amended with a change in title.

RESOLVED, That our American Medical Association support research toward 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 Behavioral Analysis Therapy~~ for Persons with Autism Spectrum Disorder, H-185.921

Our AMA support 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)

Testimony on Resolution 706 was mixed. Speakers expressing support for the resolution spoke on the importance of expanding the AMA’s support of treatment for Autism Spectrum Disorder (ASD) to be inclusive of practices beyond Applied Behavior Therapy (ABA). Testimony also discussed the harm that some autistic individuals who have received ABA report negative outcomes, while others have not. The testimony also discussed the complexity of ASD and its treatments. Speakers discussed that ABA has evolved in practice since its initial implementation and that current practices have improved. Additionally, speakers acknowledged the evidence on the potential negative implications of ABA is still evolving. Some speakers suggested referral of this resolution while others offered amendments to the third resolve. In order to fully acknowledge the complex and ever-evolving field of ASD and its therapies, it is important to support research as indicated in the first resolve clause. Therefore, your Reference Committee recommends Resolution 706 be adopted as amended.

- (14) RESOLUTION 709 - HOSPITAL BANS OF TRIAL OF LABOR AFTER CESAREAN

RECOMMENDATION A:

The first resolve of Resolution 709 be amended by addition and deletion to read as follows:

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 and appropriate resources are available. (New HOD Policy)

RECOMMENDATION B:

Resolution 709 be adopted as amended.

RECOMMENDATION C:

The Title of Resolution 709 be changed:

ACCESS TO TRIAL OF LABOR AFTER CESAREAN

HOD ACTION:

Resolution 709 adopted as amended with a title change.

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)

The testimony on Resolution 709 was generally supportive with the proffered amendments. A speaker indicated agreement with the spirit of the resolution, but expressed concern that there may be unintended downstream impacts on rural maternity care facilities. Speakers indicated the importance of patient autonomy to make the decision to attempt a Trial of Labor after Cesarean (TOLAC) following consultation with their physician and against blanket bans in hospitals. Testimony also addressed the importance of ensuring that facilities have adequate resources to support patients in case adverse events occur during a TOLAC. Your Reference Committee recommends that Resolution 709 be adopted as amended.

(15) RESOLUTION 713 - REDESIGNING THE MEDICARE HOSPICE BENEFIT

RECOMMENDATION A:

The second Resolve clause of Resolution 713 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for a reformed Medicare hospice benefit that may incorporate 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)

RECOMMENDATION B:**Resolution 713 be adopted as amended.****HOD ACTION:****Resolution 713 adopted as amended.**

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)

Testimony on Resolution 713 was mixed, especially regarding subpoints (1) and (5) of the second resolve clause. We heard testimony in support of striking subpoint (5) but did not find this compelling as there are other disease-directed therapies, such as dialysis, that need to be considered. We note that "concurrent access" does not compel treatment. We recommend additional amendments to the resolve clause and subpoint (1) to broaden the language and provide additional flexibility referenced in testimony. Therefore, your Reference Committee recommends that Resolution 713 be adopted as amended.

(16) RESOLUTION 719 - CARE PARTNER ACCESS TO MEDICAL RECORDS

RECOMMENDATION A:

The first Resolve clause of Resolution 719 be amended by addition to read as follows:

RESOLVED, That our American Medical Association advocate that electronic health records (EHR) vendors offer simplified procedures for granting proxy access and revocation 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

RECOMMENDATION B:

The second Resolve clause of Resolution 719 be amended by addition to read as follows:

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 and revocation 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

RECOMMENDATION C:

The third Resolve clause of Resolution 719 be deleted.

~~**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)~~

RECOMMENDATION D:

Resolution 719 be adopted as amended.

HOD ACTION:

Resolution 719 adopted as amended.

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)

Testimony was supportive of the first two resolve clauses of Resolution 719. Testimony noted that patients should be able to revoke access to care records. There were questions on the feasibility of the third resolve clause. Testimony noted that more regulation was needed for third-party applications as some data is not considered private health information under HIPAA. Your Reference Committee recommends striking the third resolve clause to address this concern. Your Reference Committee recommends Resolution 719 be adopted as amended.

(17) RESOLUTION 721 - USE OF ARTIFICIAL INTELLIGENCE FOR PRIOR AUTHORIZATION

RECOMMENDATION A:

Resolution 721 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for greater regulatory oversight of the use of artificial augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that: (1) is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature; (2) includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review; and (3) requires that such reviews include human examination of patient records prior to a care denial. (Directive to Take Action)

RECOMMENDATION B:

Resolution 721 be adopted as amended.

RECOMMENDATION C:

Title of Resolution 721 be changed to read as follows:

USE OF AUGMENTED INTELLIGENCE FOR PRIOR AUTHORIZATION

HOD ACTION:

Resolution 721 adopted as amended with a title change.

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)

Your Reference Committee heard testimony about the reliance on augmented intelligence in health plans' utilization management programs, particularly for prior authorization and claim denials. This is a highly concerning issue that merits additional policy to guide American Medical Association (AMA) advocacy. The Council on Medical Service proposed friendly amendments to acknowledge that payors utilize augmented intelligence algorithms for both prior authorization and claim adjudication, and to clarify that they are based on valid clinical criteria. The Council on Legislation and others testified in support of the Council on Medical Service's proposed amendments. Your Reference Committee also heard testimony that the resolution and the title used "artificial intelligence", but existing AMA policy uses "augmented intelligence." The language has been amended to be consistent with existing AMA policy. Your Reference Committee recommends Resolution 721 be adopted as amended.

- (18) RESOLUTION 726 - PROPER USE OF OVERSEAS VIRTUAL ASSISTANTS IN MEDICAL PRACTICE

RECOMMENDATION A:

The second Resolve of Resolution 726 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA study and offer formal guidance for physicians on how best to utilize overseas virtual assistants ~~in such a way as~~ to ensure protections ~~for~~ of patients, physicians, practices, and equitable employment in communities served, and patient outcomes, in a manner consistent with appropriate compliance standards.

RECOMMENDATION B:

Resolution 726 be adopted as amended.

HOD ACTION:

Resolution 726 adopted as amended.

RESOLVED, That our American Medical Association support the concept that properly trained overseas virtual assistants are an acceptable way to staff administrative roles in medical practices (New HOD Policy); and be further

RESOLVED, That our AMA study and offer formal guidance for physicians on how best to utilize overseas virtual assistants in such a way as to ensure protections for physicians, practices, and patient outcomes. (Directive to Take Action)

Testimony for Resolution 726 was mostly supportive. Speakers indicated that virtual assistants provide practices with cost-effective solutions to fill roles in their practices that are often difficult to fill with local individuals. Testimony also highlighted the particular importance of these assistants in small practices that may struggle to meet a budget allowing them to stay in practice. Speakers indicated the need to ensure that communities are not negatively impacted should practices choose to hire virtual assistants instead of community members. Additionally, concerns around the privacy of data was also expressed. Amendments were proffered to resolve each concern, and therefore your Reference Committee recommends that Resolution 726 be adopted as amended.

(19) RESOLUTION 727 - HEALTH SYSTEM CONSOLIDATION

RECOMMENDATION A:

That the first Resolve of Resolution 727 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association ~~commit to undertaking an annual~~ assess and report ~~on assessing~~ nationwide health system and hospital consolidation, as well as ~~payer consolidation~~, in order to assist policymakers and the federal government, in assessing rapidly evolving and accelerating healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation (Directive to Take Action); and be it further~~

RECOMMENDATION B:

The second Resolve of Resolution 727 be deleted.

~~RESOLVED, That our AMA annual report on nationwide hospital consolidation will be modeled after the “Competition in health insurance: A comprehensive study of U.S. Markets” in its comprehensiveness to include for example data and analyses as:~~

- ~~1. A review of the current level of hospital and/or health system consolidation at the level of all metropolitan statistical areas, state, and national markets;~~
- ~~2. A list of all mergers and acquisition transactions valued above a set threshold amount resulting in hospital and/or health system consolidation;~~
- ~~3. Analyses of how each transaction has changed or is expected to change the level of competition in the affected service and geographic markets;~~
- ~~4. Analyses of healthcare costs and prices have changes in affected markets after a large consolidation transaction has taken place (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Resolution 727 be adopted as amended.

HOD ACTION:

Resolve one of Resolution 727 adopted as amended, to read as follows:

RESOLVED, That our American Medical Association assess and report **annually on** nationwide health system and hospital consolidation, as well as payer consolidation, to assist policymakers and the federal government. (Directive to Take Action); and be it further

and resolve two restored.

RESOLVED, That our American Medical Association commit to undertaking an annual report assessing nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing rapidly evolving and accelerating healthcare consolidation for the benefit of patients

and physicians who face an existential threat from healthcare consolidation (Directive to Take Action); and be it further

RESOLVED, That our AMA annual report on nationwide hospital consolidation will be modeled after the “Competition in health insurance: A comprehensive study of U.S. Markets” in its comprehensiveness to include for example data and analyses as:

1. A review of the current level of hospital and/or health system consolidation at the level of all metropolitan statistical areas, state, and national markets;
2. A list of all mergers and acquisition transactions valued above a set threshold amount resulting in hospital and/or health system consolidation;
3. Analyses of how each transaction has changed or is expected to change the level of competition in the affected service and geographic markets;
4. Analyses of healthcare costs and prices have changes in affected markets after a large consolidation transaction has taken place (Directive to Take Action); and be it further

RESOLVED, That our AMA report the initial findings of this study to the House of Delegates by Annual 2024 (Directive to Take Action); and be it further

RESOLVED, That our AMA report the findings of this study to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy. (Directive to Take Action)

Testimony on Resolution 727 was generally supportive with some speakers questioning the prescriptive nature of the resolution language. There was testimony in opposition to an annual report on this subject, as it would be overly cumbersome and of questionable practicality. Supportive testimony centered around the timely and needed nature of the report requested in this resolution. Speakers highlighted the need for data on consolidation within health systems and payers and the issues that physicians face operating in increasingly consolidated systems. The Council on Medical Service spoke to concerns surrounding the availability of the requested data in the resolution and echoed sentiments around the concern regarding its prescriptive nature. In order to balance the need for a report on this topic and concerns regarding the feasibility of the submitted resolution, your Reference Committee recommends Resolution 727 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (20) RESOLUTION 707 - EXPEDITING REPAIRS FOR POWER AND MANUAL WHEELCHAIRS

RECOMMENDATION:

Alternate Resolution 707 be adopted in lieu of Resolution 707.

RESOLVED, That our AMA support health insurance coverage to eliminate barriers for patients to obtain wheelchair repair; ensure that repairs and services are safe, affordable, timely, and support mobility and independence for those who utilize power and manual wheelchairs; eliminate unnecessary paperwork and prior authorization requirements for basic repairs, including proof of continuous need; cover temporary rental of a substitute wheelchair when repairs require the primary wheelchair to be taken out of the home; and would include preventive maintenance and transporting the wheelchair between the patient’s home and the repair facility (New HOD Policy); and be it further

RESOLVED, That our AMA identify procedures for obtaining changes to Medicare and other payers’ current policies on repairing wheelchairs (Directive to Take Action); and be it further

RESOLVED, That our AMA support suppliers of power and manual wheelchairs providing preventive maintenance and repair services for wheelchairs they supply to patients and permits consumers to perform self-repairs as permitted by the manufacturer and when it does not void the warranty. (New HOD Policy)

HOD ACTION:

Alternate Resolution 707 adopted in lieu of Resolution 707.

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)

Your Reference Committee heard testimony recognizing the critical importance of access to and insurance coverage of wheelchairs as patients rely on wheelchairs to maintain mobility and quality of life. Testimony from the Council on Medical Service appreciates that this resolution addresses the issue of wheelchair repairs – a topic currently unaddressed in AMA policy. The Council offered substitute language to streamline the resolution. The Council also proposed adding an additional resolve clause stating that our AMA shall identify the insurer procedural changes needed to enable coverage for wheelchair repairs, which acknowledges that this is a new policy pursuit that may require new advocacy strategies. Additionally, there was conflicting testimony on self-repair of wheelchairs due to risk of injury and voiding the warranty. Your Reference Committee amended the language to be supportive of self-repairs that are permitted by the manufacturer and will not void the warranty. Therefore, your Reference Committee recommends Alternate Resolution 707 be adopted in lieu of Resolution 707.

- (21) RESOLUTION 711 - DOCTORS' RISK FOR TERMINATION OF LIABILITY COVERAGE OR MEDICAL PRIVILEGES CONSEQUENT TO *DOBBS*

RECOMMENDATION A:

Policy D-5.999(6) be amended by addition to read as follows:

Preserving Access to Reproductive Health Services D-5.999
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion;

(3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage, against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion. (Modify AMA Policy)

RECOMMENDATION B:

Alternate Resolution 711 be adopted in lieu of Resolution 711.

HOD ACTION:

Alternate Resolution 711 adopted in lieu of Resolution 711 to read as follows:

Preserving Access to Reproductive Health Services D-5.999

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage, or clinical privileges, against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive

reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion. (Modify AMA Policy)

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)

Testimony on Resolution 711 was mixed, but primarily supportive. Speakers indicated the need for physician protection against consequences when practicing in the everchanging legal landscape surrounding abortion. Testimony noted the importance for ensuring that physicians are able to practice evidence-based care when indicated and legal in their state. Testimony indicated strong and unanimous opposition to the criminalization of abortion care and against any adverse impacts. The Council on Medical Service and other speakers indicated support for the spirit of the resolution but had concerns around the wording of the resolve and encouraged the amendment of existing policy. Your reference committee recommends adoption of alternate Resolution 711 in lieu of Resolution 711.

- (22) RESOLUTION 718 - INSURANCE COVERAGE OF FDA APPROVED MEDICATIONS AND DEVICES

RECOMMENDATION A:

Policy H-100.991 be amended by addition to read as follows:

RESOLVED, That our American Medical Association amend Policy H-100.991 by addition to read as follows:

Drug and Device Availability, H-100.991

Our AMA urges the Department of Health and Human Services HHS, as well as all other health plans, to consider all drugs and devices approved by the Food and Drug Administration FDA for marketing as eligible for reimbursement. (Modify AMA Policy)

RECOMMENDATION B:

Alternate Resolution 718 be adopted in lieu of Resolution 718.

HOD ACTION:

Alternate Resolution 718 adopted in lieu of Resolution 718, to read as follows:

RESOLVED, That our American Medical Association amend Policy H-100.991 by addition to read as follows:

Drug and Device Availability, H-100.991

Our AMA urges the Department of Health and Human Services, as well as all other health plans, to consider all drugs and devices

approved by the Food and Drug Administration for marketing as eligible for immediate reimbursement. (Modify AMA Policy)

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)

Your Reference Committee heard testimony supportive of the resolution that would give patients access to medical devices that would be eligible for reimbursement, upon Food and Drug Administration (FDA) approval. The Council of Medical Service testified that they believe that the goal of Resolution 718 could be more efficiently accomplished by simply expanding the scope of Policy H-100.991 to include medical devices and to include all types of health plans – not just those regulated by the Department of Health and Human Services (HHS). Your Reference Committee agreed with the Council to amend H-100.991 instead of adopting Res 718.

- (23) RESOLUTION 720 - PRIOR AUTHORIZATION COSTS, AMA UPDATE TO CMS

RECOMMENDATION:

Alternate Resolution 720 be adopted in lieu of Resolution 720.

RESOLVED, That our AMA continue to conduct research on the costs associated with prior authorization by utilizing AMA and other data sources. (Directive to Take Action)

HOD ACTION:

Alternate Resolution 720 adopted in lieu of Resolution 720.

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)

Testimony acknowledged bold AMA efforts to address prior authorization burdens and has included fixing prior authorization as a pillar of the AMA Recovery Plan for Physicians. Your Reference Committee heard conflicting testimony on the benefits and risks of quantifying practice costs of prior authorization. The Council on Medical Service expressed support for the underlying intent of this resolution, which is to bolster our AMA's multi-pronged advocacy on this issue with additional information capturing the administrative costs associated with this process. However, the Council notes that the practice expense survey referenced in the resolution is, after years of preparation, already out in the field. As such, it is not feasible to add survey questions regarding prior authorization costs to the survey. Your Reference Committee agrees with suggested substitute language offered by the Council on Medical Service, which offers an alternate approach to further research on this topic.

- (24) RESOLUTION 723 - VERTICAL CONSOLIDATION IN HEALTH CARE - MARKETS OR MONOPOLIES

RECOMMENDATION:

Alternate Resolution 723 be adopted in lieu of Resolution 723.

RESOLVED, That our American Medical Association advocate against anticompetitive business practices that have the potential to

adversely affect the physician patient relationship, to result in higher costs or decreased quality of care, or are not in the best interest of patients, the public and/or physicians (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts to increase transparency, review, and enforcement of laws with respect to vertical mergers that have the potential to negatively impact the health care industry (New HOD Policy); and be it further

RESOLVED, That our AMA work with all appropriate stakeholders to create model legislation to prohibit anticompetitive business practices within the health care sector. (Directive to Take Action)

HOD ACTION:

Alternate Resolution 723 adopted in lieu of Resolution 723.

RESOLVED, That our American Medical Association advocate to address the issue of potential antitrust violations as a result of vertical consolidation in the health care industry (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association advocate to address the June 30, 2020, Vertical Merger Guidelines' impact on the physician sector, to prevent anticompetitive mergers, acquisitions, and monopolies/oligopolies. (Directive to Take Action)

Your Reference Committee heard testimony that was supportive of Resolution 723. There was testimony heard from the authors that they wished to strike the original second resolve clause. There was additional testimony in support of the alternate language presented here. The alternate language proffered captures the intent of the resolution and provides a clear direction on actions the AMA can take to address consolidation in health care. We heard strong testimony in support of the AMA taking steps to proactively address these issues. Therefore, your Reference Committee recommends that Alternate Resolution 723 be adopted in lieu of Resolution 723.

RECOMMENDED FOR REFERRAL

- (25) RESOLUTION 710 - PROTECT PATIENTS WITH MEDICAL DEBT BURDEN
RESOLUTION 712 - MEDICAL BANKRUPTCY - A UNIQUE FEATURE IN THE USA

RECOMMENDATION:

Resolutions 710 and 712 be referred.

HOD ACTION:

Resolutions 710 and 712 referred.

RESOLUTION 710

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)

RESOLUTION 712

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)

Testimony was supportive of the spirit of both Resolution 710 and 712. Your Reference Committee recommends considering these items in tandem, as they are related. Although we agree with testimony that this issue is timely and crucial for our patients, it would be best served by a comprehensive study to develop appropriate policies. Testimony noted that the topic is complicated and nuanced and needs to be studied further so the most optimal and actionable policy can be crafted. During testimony, the Council on Medical Service supported referral of both items and indicated the Council would be willing to study this issue if it was assigned to them.

Your Reference Committee recommends that Resolution 710 and Resolution 712 be referred.

(26) RESOLUTION 715 - PUBLISHED METRICS FOR HOSPITALS AND HOSPITAL SYSTEMS

RECOMMENDATION:

Resolution 715 be referred.

HOD ACTION:

Resolution 715 referred with report back no later than the 2024 Interim Meeting of the House of Delegates.

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)

Testimony on Resolution 715 was mixed. Speakers indicated the need for transparency in hospitals' and hospital systems' treatment of physicians. Testimony indicated that this resolution could assist in collecting physician turnover data and allow for greater physician awareness when selecting employment. The Board of Trustees testified about the AMA's ongoing efforts in the Joy in Medicine program, which incentivizes hospitals and hospital systems efforts to improve the physician experience. However, while other speakers agreed to the importance of this topic, concern was expressed surrounding potential unintended adverse consequences of collecting and reporting this information. Testimony discussed the complexity of these types of reporting and questioned the feasibility of the resolution. Finally, testimony indicated that this topic needs to be further investigated and that corporate entities and other large employers of physicians could, and potentially should, be included in the entities from which information is collected. To allow for a more in depth understanding of the topic presented in this resolution, your Reference Committee recommends that Resolution 715 be referred.

(27) RESOLUTION 722 - EXPANDING PROTECTIONS OF END-OF-LIFE CARE

RECOMMENDATION:

Resolution 722 be referred.

HOD ACTION:**Resolution 722 referred.**

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)

Testimony on Resolution 722 was mixed. There was testimony supporting reaffirmation of clauses 1-6 and concern with the wording of clauses 7-8. Your Reference Committee heard testimony that questioned how to define “end-of-life care” and believes this resolution should be referred for further study. Your Reference Committee also heard testimony that “end-of-life care” is defined differently state by state and those differences need to be considered. Finally, your Reference Committee heard testimony questioning the legal implications of clauses 7 and 8, as well as some of the amendments offered. Therefore, your Reference Committee recommends Resolution 722 be referred.

- (28) RESOLUTION 725 - THE ECONOMICS OF PRIOR AUTHORIZATION

RECOMMENDATION:**Resolution 725 be referred.****HOD ACTION:****Resolution 725 referred.**

RESOLVED, That our American Medical Association advocate to the federal government that third party payors and surrogates include economic information on the net costs of medications denied prior authorization and, where applicable, comparative net costs of alternative approved or suggested medications for each rejected prior authorization. (Directive to Take Action)

Our AMA acknowledges the critical need to address prior authorization burdens and has included fixing prior authorization as a pillar of the AMA Recovery Plan for Physicians. Your Reference Committee heard testimony requesting greater drug price transparency as well as requests for the reduction in the number of prior authorizations. However, the Council of Medical Service inquired what costs would be assessed. Further, the title of the resolution describes the economics of prior authorization, but the resolve alludes to only the costs of prescription drugs. Due to the various issues that this poses, your Reference Committee recommends that this resolution be referred to better assess avenues for collecting such data and uses of such data.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

- (29) RESOLUTION 705 - AGING AND DEMENTIA FRIENDLY HEALTH SYSTEMS

RECOMMENDATION:

Policies H-280.944 and H-280.945 be reaffirmed in lieu of Resolution 705.

HOD ACTION:

Policies H-280.944 and H-280.945 reaffirmed in lieu of Resolution 705.

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)

Your Reference Committee heard testimony that was supportive of the spirit of this resolution; however, compelling testimony from the Council on Medical Service directed our attention to a recent Council report on this topic. Council on Medical Service Report 4-I-21 established Policy H-280.944 and reaffirmed Policy H-280.945. Your Reference Committee agrees with testimony that this is an important and timely issue; however, it is clear that the AMA has policy to address these concerns. Testimony noted that accessing these services in rural areas is especially challenging and your Reference Committee would encourage the AMA to explore ways to improve rural access to aging and dementia services.

Your Reference Committee believes this resolution is addressed by these policies and recommends Policies H-280.944 and H-280.945 be adopted in lieu of Resolution 705.

Financing of Home and Community-Based Services H-280.944

Our AMA supports: (1) federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS); (2) policies that help train, retain, and develop an adequate HCBS workforce; (3) efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS; (4) that Medicaid’s Money Follows the Person demonstration program be extended or made permanent; (5) cross-agency and federal-state strategies that can help improve coordination among HCBS programs and streamline funding and the provision of services; (6) HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices; and (7) that the Centers for Medicare and Medicaid Services and private insurers extend flexibility to implement innovative programs including but not limited to hospital at home programs.

Financing of Long-Term Services and Supports H-280.945

Our AMA supports:

- (1) policies that standardize and simplify private LTCI to achieve increased coverage and improved affordability;
- (2) adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees;
- (3) allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI;

- (4) innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities;
- (5) permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy;
- (6) Medicare Advantage plans offering LTSS in their benefit packages;
- (7) permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit;
- (8) a back-end public catastrophic long-term care insurance program;
- (9) incentivizing states to expand the availability of and access to home and community-based services; and
- (10) better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.
- (30) RESOLUTION 728 - DISCHARGE CONSOLIDATED CLINICAL DOCUMENT ARCHITECTURE (C-CDA) MINIMUM DATA SET CONTENT AND ORDER PRIORITY

RECOMMENDATION:

Policies D-160.913, D-478.973, and D-478.996 be reaffirmed in lieu of Resolution 728.

HOD ACTION:

Policies D-160.913, D-478.973, and D-478.996 reaffirmed in lieu of Resolution 728.

RESOLVED, That our American Medical Association support use of standardized minimum data set content such as the standardized Consolidated Clinical Document Architecture (C-CDA) for use in an electronic discharge summary with electronic health record vendors and health information exchanges, with inclusion of the following elements:

Discharge Consolidated Document Architecture (C-CDA) Minimum Data-Set Content and Order Priority

1. Discharge summary narrative (aka hospital course)
2. Discharge medications
3. Allergies
4. Admission diagnosis
5. Discharge diagnosis
6. Procedures – including interventional radiology, cardiac catheterization, and operative procedures
7. Diagnostic imaging – advanced imaging, for example: MRI, CT, PET, nuclear imaging, ultrasound, echo, and venous Doppler
8. Laboratory – first and last laboratory result for every test recommended, rare tests – which are performed only once – included (e.g., ANA rheumatoid test)
9. Consultations
10. Assessment and plan (includes future orders for follow-up with primary care physician and diagnostic tests)
11. Problem list.

(New HOD Policy)

Testimony on Resolution 728 was extremely limited, with one speaker indicating concern with the use of “support” in the resolve. There was no testimony received from the author. Therefore, your Reference Committee recommends that Policies D-160.913, D-478.973, and D-478.996 be reaffirmed in lieu of Resolution 728.

DISCHARGE SUMMARY REFORM D-160.913

Our AMA will coordinate with interested stakeholders to develop a model discharge summary that: (1) is concise but informational; (2) promotes excellent and safe patient care; and (3) improves coordinated discharge planning.

PRINCIPLES FOR HOSPITAL SPONSORED ELECTRONIC HEALTH RECORDS D-478.973

1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.
4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.