MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY

Donald J. Palmisano, MD, JD
Introduced by the Louisiana Delegation

Whereas, Donald J. Palmisano, MD, JD, passed away on November 23, 2022; and

Whereas, Dr. Palmisano obtained his medical degree from the Tulane School of Medicine in New Orleans, Louisiana in 1963; and

Whereas, Dr. Palmisano then completed his residency training in general surgery at Charity Hospital, affectionately known to the locals in New Orleans as Big Charity, followed by two years of active duty in the United States Air Force as Chief of Surgery with the 821st Med Group at Ellsworth Air Force Base in South Dakota; and

Whereas, Dr. Palmisano entered the private sector where he practiced general and vascular surgery for 35 years with his brother-in-law and other partners until he was forced to close his practice in 2005 when Hurricane Katrina destroyed the hospitals and homes of his patients; and

Whereas, Dr. Palmisano was a key participant and champion in the development and passage of the Louisiana Medical Malpractice Act of 1975, which placed a total cap on all damages, and was later amended in 1984 to include unlimited future medical payments as incurred; and

Whereas, Dr. Palmisano was once sued for medical malpractice by a patient he had never seen, he decided to attend law school to better understand how such cases were litigated and Dr. Palmisano graduated from the Loyola University College of Law in New Orleans in 1982; and

Whereas, Dr. Palmisano was one of the founding members of the Louisiana Medical Mutual Insurance Company (LAMMICO) and served on the board of directors from 1982 to 1989 as secretary and vice president of claims; and

Whereas, Dr. Palmisano served on the board of directors of The Doctors Company, a physician-owned medical malpractice insurer based in Napa, CA from 2004 to 2019; and

Whereas, in 1989 Dr. Palmisano combined his knowledge of medicine and law to form Intrepid Resources, which provided consulting services for patient safety, risk management, and medical malpractice defense; and

Whereas, Dr. Palmisano was an active member of the Louisiana State Medical Society and served in many capacities over the years including as the 105th President of the Society during 1984-1985; and

Whereas, Dr. Palmisano was also active within the American Medical Association, serving a trustee on the AMA Board of Trustees, and as Secretary/Treasurer prior to serving as President during 2003-2004; and

Whereas, Dr. Palmisano gave thousands of speeches, media interviews, and testimony before the United States Congress on medical liability reform, antitrust issues, health system reform, patient safety and more; and

Whereas, Dr. Palmisano was also an accomplished author having published three books “On Leadership: Essential Principles for Success” (2008); “The Little Red Book of Leadership Lessons” (2012); and “A Leader’s Guide to Giving a Memorable Speech” (2020); and

Whereas, Dr. Palmisano received many awards over his career including but not limited to the Air Force Commendation Medal (1970); Loyola University’s President Medal (2005); the LSMS Dave Tarver Distinguished Service Award (2020); and

Whereas, Dr. Palmisano, was a renaissance man who enjoyed many talents in areas outside of medicine and law. He will always be remembered as an accomplished author, photographer, lateral thinker, raconteur, sports car enthusiast, instrument rated pilot, gentleman, patriot, and a friend; and

Whereas, Dr. Palmisano was a loving and devoted husband to his wife, Robin, father to daughter Mary Ellen, father to Donna and her husband Jerry, father to son Donald Jr. and wife Ana, and grandfather to seven wonderful grandchildren, Brittany, Ryan, Marco, Alexis, Diego, Pablo and Nico, and great grandfather to Meryl and Lainey; and

Whereas, Dr. Palmisano lived his life based on advice from his father that he passed onto his family, which simply stated that in order to achieve success "Do your homework, have courage, and don't give up"; therefore be it

RESOLVED, That our American Medical Association acknowledge with deep gratitude and sincere appreciation the lifelong work performed by Donald J. Palmisano, MD, JD, in service to the practice of medicine; and be it further

RESOLVED, That our AMA extend its heartfelt condolences to the family of Donald J. Palmisano, MD, JD, and adopt this resolution as an expression of deepest respect for our colleague and dear friend; and be it further

RESOLVED, That a copy of this memorial resolution be forwarded to Dr. Palmisano's family.

VENKAT K. RAO, MD
Introduced by the Michigan Delegation to the AMA

Whereas, Venkat K. Rao, MD, a physician trained in trained in Internal Medicine with specialties in Pulmonary, Critical Care, and Sleep Medicine, was born August 5, 1951, and passed away on June 3, 2023; and

Whereas, Doctor Rao grew up in Chintagumpala, India, came to the United States in 1976, and resided in mid-Michigan for more than 30 years; and

Whereas, Doctor Rao was a family man, friend, and servant leader; and

Whereas, Doctor Rao utilized his knowledge, compassion, and leadership attributes to improve the profession of medicine, provide opportunities to physicians in training, and strengthen his community; and

Whereas, Doctor Rao, in addition to holding the position of Chair of Internal Medicine at McLaren Flint, volunteered much of his time to serving on medical boards and committees at the local, state, and national level; and

Whereas, so many people's lives were impacted for the better through Doctor Rao's care as a physician and generous contributions of his time and expertise to organizations, including but not limited to, the Michigan State Medical Society, Genesee County Medical Society, and Foundation for Mott Community College where he served or was serving on their respective Boards; and

Whereas, Doctor Rao was appointed to the Michigan Board of Medicine in 2017, reappointed in 2021, and elected as Chair earlier this year; and

Whereas, Doctor Rao was a current member of the Michigan Delegation to the American Medical Association, serving with distinction for 11 years. He dedicated many years to the AMA International Medical Graduate Section, volunteering on many of their committees; and

Whereas, Doctor Rao was a tireless physician who gave generously of his time; and

Whereas, Doctor Rao was a leader, mentor, and motivator to many; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize and honor Venkat K. Rao, MD, for his outstanding service to the profession of medicine and the countless patients whose lives were touched by his hard work and dedication.

RESOLVED, That our American Medical Association House of Delegates extend its deepest sympathy to the family members of Venkat K. Rao, MD.

Martin Kevin Dineen MD, FACS

Introduced by American Association of Clinical Urologists, American Urological Association

Whereas, Dr. Marty K. Dineen was not only a gifted Urologic Surgeon and a tireless physician's advocate for organized medicine, he also served our AMA as Delegate of the American Association of Clinical Urologists; and

Whereas, Dr. Dineen earned his Bachelor of Science in Biology from the University of Notre Dame and his medical degree from Louisiana State University (LSU). Following his surgical internship and residency in urology at LSU he then completed a fellowship in the Department of Urologic Oncology at Roswell Park Memorial Institute. Later he joined Atlantic Urological Associates (now Advanced Urology Institute) and began his urologic practice in Ormond Beach, Florida that would span 36 years; and

Whereas, Dr. Dineen served as President of the American Association of Clinical Urologists, President of the Southeastern Section of the American Urological Association (AUA), and President of the Florida Urological Society. He was also a founding member of the Board of Directors of the Urology Care Foundation. Marty was an early proponent and pioneer of Ambulatory Surgical Center development and the movement of inpatient urological services to the outpatient setting, founding one of the first ambulatory surgery centers in the nation; and

Whereas, Marty served on the AUA Public Policy Council and the AUA Coding & Reimbursement Committee in addition to serving on its Board of Directors. The AUA Southeastern Section recognizes Dr. Dineen with the Gee-Dineen Socio-Economic session at each annual meeting; and

Whereas, Dr. Dineen was awarded the AUA Distinguished Service Award for over two decades of outstanding leadership in Health Policy as well as humanitarian service in Haiti to treat urogenital elephantiasis. Since October 2006, Dr. Dineen worked with fellow urologists in Leogane, Haiti, to perform over 2,000 hydrocele surgeries. Dr. Dineen was recognized by his University of Notre Dame with the Dr. Tom Dooley Society Founders Award for his humanitarian efforts. In Haiti there is a medical clinic currently being built in his honor. Recently, Marty was awarded the Lifetime Achievement Award for his contributions to urology by the Florida Urological Society; and

Whereas, Dr. Dineen held appointments as a clinical Assistant Professor of Urology at The University of South Florida School of Medicine and Associate Professor of Urology at The University of Florida Health Sciences Center. He was a mentor to many urology residents and enjoyed teaching them. He served as a peer review editor for the journal UROLOGY and UROLOGY PRACTICE; and

Whereas, Marty was a wonderful husband, father, grandfather, brother, son and friend. He was a talented singer who sang with the Daytona Beach Bel Canto singers for many years; a gifted piano player, pilot, and was also well known for his delicious pies. He coached several local sports teams and sponsored several throughout the community. Like his father, he was an Eagle Scout, a tradition that continued with his son Ryan, for whom he served as a Boy Scout troop leader. He will long be remembered for his sense of humor, generosity and selflessness; therefore be it

RESOLVED, That our American Medical Association recognize the many contributions made by Dr. Martin Kevin Dineen to the medical profession as well as the Urological community; and be it further

RESOLVED, That our American Medical Association express its sympathy for the passing of Dr. Dineen to his family and present them with a copy of this resolution.

Kathryn L. Moseley, MD. MPH
Introduced by the Council on Ethical and Judicial Affairs

Whereas, Kathryn L. Moseley, MD, MPH, served with wisdom and grace as a member of the Council on Ethical and Judicial Affairs from 2013 to 2020, ably chairing the council in 2019-2020; and

Whereas, Dr. Moseley similarly served patients and her profession as a member of the Committee on Bioethics of the American Academy of Pediatrics and the Ethics Committee of the American Board of Pediatrics, as Director of Biomedical Ethics for the Henry Ford Health System in Detroit, Michigan, and as a member of the faculty of the Center for Bioethics and Social Sciences in Medicine of the University of Michigan; and

Whereas, Dr. Moseley participated as a member of AMA's Writing Group on the History of African Americans and the Medical Profession, a project instrumental in bringing public attention to racism within the profession; and

Whereas, Dr. Moseley brought her training in not only medicine, ethics, and public health but also theology to bear on issues of trust and health disparities, especially within communities of color, as a researcher and a member of the faculty of the Health Disparities Research Program of the Michigan Institute for Clinical and Health Research at the University of Michigan; and

Whereas, Kathryn L. Moseley, MD, MPH, passed away on June 3, 2023, at the age of 70; therefore be it

RESOLVED, That our American Medical Association express the utmost respect for Kathryn L. Moseley, MD, MPH, and honor her legacy of devotion to the interests of patients and the integrity of the profession she loved and served with dedication.

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Saturday, June 10. The following resolutions were dealt with on the reaffirmation calendar: 111, 114, 115, 229, 232, 233, 238, 242, 243, 248, 249, 250, 252, 253, 317, 523, 524 and 717.

Alternate resolutions are considered to have been introduced by the reference committee.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

1. OPPOSING MANDATED REPORTING OF LGBTQ+ STATUS
Introduced by Medical Student Section

Resolution 001 was considered with Resolution 018.
See Resolution 018.

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.

2. EXCLUSION OF RACE, PREFERRED SPOKEN LANGUAGE, AND ETHNICITY IN THE FIRST SENTENCE OF CASE REPORTS
Introduced by Medical Student Section

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

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-315.961

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; and be it further

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.

3. LAYING THE FIRST STEPS TOWARDS A TRANSITION TO A FINANCIAL AND CITIZENSHIP NEED BLIND MODEL FOR ORGAN PROCUREMENT AND TRANSPLANTATION
Introduced by Medical Student Section

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

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-370.954 and H-370.982

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; 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; and be it further

RESOLVED, That our AMA amend H-370.982 by addition to read as follows:

(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~~, 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 ethically available means.

4. AMENDING POLICY H-525.988, "SEX AND GENDER DIFFERENCES IN MEDICAL RESEARCH"
Introduced by Medical Student Section

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

HOD ACTION: SUBSECTION (7) REFERRED
REMAINDER ADOPTED AS FOLLOWS
See Policy H-525.988

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

[Editor's note: The following subsection (7) was referred.]

(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.

5. PROVIDING CULTURALLY AND RELIGIOUSLY SENSITIVE ATTIRE OPTIONS AT HOSPITALS FOR PATIENTS AND EMPLOYEES
Introduced by Medical Student Section

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

HOD ACTION: **ADOPTED**
See Policy H-65.944

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.

6. ENSURING PRIVACY IN RETAIL HEALTHCARE SETTINGS
Introduced by American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association

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

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-315.960

RESOLVED, That our American Medical Association study privacy protections, privacy consent practices, the potential for data breaches, and the use of health data for non-clinical purposes in retail settings.

7. INDEPENDENT MEDICAL EVALUATION
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

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

HOD ACTION: REFERRED FOR DECISION

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 patients.

8. STUDY ON THE CRIMINALIZATION OF THE PRACTICE OF MEDICINE
Introduced by American Society of Addiction Medicine

Resolution 008 was considered with Resolution 015.
See 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 HOD no later than the June, 2024 Annual Meeting.

9. RACISM - A THREAT TO PUBLIC HEALTH
Introduced by Minnesota

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

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-405.970

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 to document the clinical impact of racism, and capture the data needed to help provide more effective patient care.

10. ADVOCATING FOR INCREASED SUPPORT TO PHYSICIANS IN FAMILY PLANNING AND FERTILITY
Introduced by Women Physicians Section

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

HOD ACTION: ADOPTED
See Policy D-405.944

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; and be it further

11. RIGHTS OF THE DEVELOPING BABY
Introduced by Dr. Thomas W. Eppes, MD, Delegate

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

HOD ACTION: 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.

12. VIABILITY OF THE NEWBORN
Introduced by Dr. Thomas W. Eppes, MD, Delegate

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

HOD ACTION: 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.

13. SERIAL (REPEATED) SPERM DONORS
Introduced by Illinois

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

HOD ACTION: 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.

14. REDRESSING THE HARMS OF MISUSING RACE IN MEDICINE
Introduced by Minority Affairs Section, National Medical Association

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

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-65.943

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 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; and be it further

RESOLVED, That our AMA advocate for 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.

15. REPORT REGARDING THE CRIMINALIZATION OF PROVIDING MEDICAL CARE
Introduced by New York

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

HOD ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 008
See Policy H-80.992

RESOLVED, That our American Medical Association study the changing environment in which some medical practices have been criminalized including: the degree to which such criminalization is based or not based upon valid scientific findings, 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 back to the HOD no later than the November 2023 Interim meeting.

16. SUPPORTING EFFORTS TO STRENGTHEN MEDICAL STAFFS THROUGH COLLECTIVE ACTIONS AND/OR UNIONIZATION
Introduced by Organized Medical Staff Section

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

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-405.946

RESOLVED, That our American Medical Association reevaluate the various efforts to achieve collective actions and/or unionization for physicians nationally; 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

17. ESTABLISHING A FORMAL DEFINITION OF "EMPLOYED PHYSICIAN"
Introduced by Organized Medical Staff Section

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

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-405.945

RESOLVED, That our American Medical Association adopt the following as its definition of "employed physician": An employed physician is any physician 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."

18. CONFIDENTIALITY OF SEXUAL ORIENTATION AND GENDER IDENTITY DATA
Introduced by Resident and Fellow Section

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

HOD ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 001
See Policy H-65.959

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.

REFERENCE COMMITTEE A

101. UPDATING PHYSICIAN JOB DESCRIPTION FOR DISABILITY INSURANCE
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-330.869

RESOLVED, That our American Medical Association support efforts to develop 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.

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

102. REFORMING THE MEDICARE PART B "BUY AND BILL" PROCESS TO ENCOURAGE BIOSIMILAR USE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: 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.

103. MOVEMENT AWAY FROM EMPLOYER-SPONSORED HEALTH INSURANCE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: 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.~~

b~~e~~. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.

c~~d~~. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.

d~~e~~. The public option is financially self-sustaining and has uniform solvency requirements.

e~~f~~. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.

f~~g~~. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:

a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.

b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.
4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.

104. SUPPORT FOR HOUSING MODIFICATION POLICIES

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ALTERNATE RESOLUTION 104 ADOPTED
See Policy H-160.890

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; 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.

105. STUDYING POPULATION-BASED PAYMENT POLICY DISPARITIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-200.954, H-290.976, H-385.921 and H-400.969

RESOLVED, That our American Medical Association support 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; and be it further

RESOLVED, That our AMA support the ongoing effort of members of the federation to analyze the valuation of CPT codes describing similar services by gender to ensure equitable valuation; 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.

106. BILLING FOR TRADITIONAL HEALING SERVICES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: 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.

107. REDUCING THE COST OF LIMITED DATA SETS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-330.868

RESOLVED, That our American Medical Association support reduced pricing of limited data sets for academic, nonprofit, and government researchers use.

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.

108. SUSTAINABLE REIMBURSEMENT FOR COMMUNITY PRACTICES
Introduced by District of Columbia

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: 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; and be it further

RESOLVED, That our AMA study and report back on remedies for such reimbursement rates for physician practices; and be it further

RESOLVED, That our AMA 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; 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.

109. IMPROVED ACCESS TO CARE FOR PATIENTS IN CUSTODY OF PROTECTIVE SERVICES
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-385.903

RESOLVED, That our American Medical Association support mechanisms to improve payment for physician services provided to patients under protective services custody.

110. LONG-TERM CARE COVERAGE FOR DEMENTIA PATIENTS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-280.991

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.

111. POTENTIAL NEGATIVE CONSEQUENCES OF ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Introduced by American Academy of Dermatology, Pennsylvania, The American Society of Dermatopathology, Society for Investigative Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery

Considered on reaffirmation calendar.

HOD ACTION: POLICY D-385.963, H-160.915, H-385.913, D-385.952, H-385.907, D-385.953, AND H-385.904 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for the provision of health care and reimbursement models that are in the best interest of patients and offer risk adjustment methodologies to prevent financial penalty to the physician and other healthcare team members who provide care for the sickest patients; and be it further

RESOLVED, That our AMA oppose capitation care healthcare systems, such as ACOs, when such systems place physicians and other healthcare team members at financial risk for the overall healthcare costs of their patients, including costs attributable to care provided by other entities; and be it further

RESOLVED, That our AMA advocate for flexible pathways for small practice participation in ACOs that greatly mitigate ACO participation-related bureaucratic burdens and help protect small practices from large financial penalties otherwise assigned to large health systems for cost overages; and be it further

RESOLVED, That our AMA oppose CMS mandates that require Medicare beneficiaries to enroll in ACOs; and be it further

RESOLVED, That our AMA oppose the expansion of capitation care systems, such as ACOs, as a means of providing coverage and services for all Medicare enrollees.

112. REMOVAL OF BARRIERS TO CARE FOR LUNG CANCER SCREENING IN MEDICAID PROGRAMS

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ALTERNATE RESOLUTION 112 ADOPTED
See Policy H-185.936

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.

113. COST OF INSULIN

Introduced by Georgia

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: POLICIES H-110.984, H-110.986, AND H-110.990 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

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.

114. PHYSICIAN AND TRAINEE LITERACY OF HEALTHCARE COSTS
Introduced by Illinois

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-155.966, D-155.987, D-295.316, AND H-373.998 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association endorse price transparency within all sectors of the healthcare market; and be it further

RESOLVED, That our AMA encourage all physician employers, including hospitals, to allow their healthcare professionals access to accurate and easily understandable costs of any laboratory test, procedure, medication, medical supply, or any other cost related to medical care within and outside their organization; and be it further

RESOLVED, That our AMA advocate for all physician employers, including hospitals, to empower their healthcare professionals to incorporate discussions on healthcare costs during patient counseling; and be it further

RESOLVED, That our AMA advocate for medical education inclusive of price transparency, financial literacy, and the economics and financing of healthcare delivery; and be it further

RESOLVED, That our AMA work with the Commission of Osteopathic College Accreditation (COCA), the Liaison Committee on Medical Education (LCME), the Accreditation Council on Graduate Medical Education (ACGME), and other relevant stakeholders, to include price transparency and healthcare financing in medical education as components of program accreditation; and be it further

RESOLVED, That our AMA study the issues around price transparency, including the feasibility of providing accurate and easily understandable costs of tests, procedures, medications, and other costs related to medical care.

115. ADVOCATING FOR ALL PAYER COVERAGE OF WIGS FOR PATIENTS UNDERGOING TREATMENT FOR CANCER
Introduced by Illinois

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-55.999, H-165.856 AND H-185.964 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association urge all payers to consider that wigs, cold caps, and medically necessary cranial prosthetics may have significant benefits to improve the quality of life for patients with cancer; and be it further

RESOLVED, That our AMA work with relevant stakeholders such as the Centers for Medicare and Medicaid Services to encourage payers to cover costs associated with wigs, cold caps, and medically necessary cranial prosthetics for patients with alopecia secondary to cancer treatments; and be it further

RESOLVED, That our AMA work with all relevant medical specialty societies, third party payers, including The Centers for Medicare & Medicaid Services (CMS), and other national stakeholders as deemed appropriate to require third party payers to include reimbursement for wigs, cold caps, and medically necessary cranial prosthetics for patients with alopecia secondary to cancer treatment.

116. MEDICARE COVERAGE OF OTC NICOTINE REPLACEMENT THERAPY
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-490.973

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.

117. PAYMENT FOR PHYSICIANS WHO PRACTICE STREET MEDICINE
Introduced by Texas

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED
See Policy H-160.886

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; 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."

118. ADVANCING ACUTE CARE AT HOME
Introduced by Integrated Physician Practice Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 120
See Policy D-160.910

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; and be it further

RESOLVED, That the AMA, in coordination with other acute care at home advocacy groups, identify avenues for addressing state regulatory concerns; and be it further

RESOLVED, That the AMA engage with allied health professional organizations to share perspectives and address concerns about the benefits and challenges of acute care at home.

119. RESCINDING THE MEDICARE THREE-DAY HOSPITAL INPATIENT REQUIREMENT FOR NURSING HOME ADMISSION
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-280.947

RESOLVED, That our American Medical Association 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.

120. SUPPORTING PERMANENT REIMBURSEMENT OF ACUTE HOSPITAL CARE AT HOME
Introduced by Organized Medical Staff Section

Resolution 120 was considered with Resolutions 118.
See Resolution 118.

RESOLVED, That our American Medical Association 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; 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; 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.

REFERENCE COMMITTEE B

201. OPPOSITION TO PHARMACISTS TESTING, DIAGNOSING, AND TREATING MEDICAL CONDITIONS
Introduced by American Association of Clinical Urologists and American Urological Association

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-35.977

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 medical conditions.

202. SUPPORT FOR MENTAL HEALTH COURTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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.

203. DRUG POLICY REFORM
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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; 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; 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.

204. SUPPORTING HARM REDUCTION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

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

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

205. AMENDING H-160.903, ERADICATING HOMELESSNESS, TO REDUCE EVICTIONS AND PREVENT HOMELESSNESS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICY H-160-903 BE REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

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.

206. TRIBAL PUBLIC HEALTH AUTHORITY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-350.950

RESOLVED, That our AMA support the Department of Health and Human Services issuing guidance, through the Centers for Disease Control and Prevention and the Indian Health Service, on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers.

RESOLVED, That our AMA 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.

207. INSURANCE COVERAGE OF GROUND AMBULANCE SERVICES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-185.914

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

208. MEDICAID MANAGED CARE FOR INDIAN HEALTH CARE PROVIDERS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-350.949

RESOLVED, That our American Medical Association 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 with their legal obligations to Indian health care providers; and be it further

RESOLVED, That our AMA 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.

209. PURCHASED AND REFERRED CARE EXPANSION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-350.948

RESOLVED, That our American Medical Association advocate 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.

210. THE HEALTH CARE RELATED EFFECTS OF RECENT CHANGES TO THE US MEXICO BORDER
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-350.975, D-160.988, D-65.992, AND D-255.980 BE REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

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; 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.

211. AMENDING POLICY H-80.999, "SEXUAL ASSAULT SURVIVORS", TO IMPROVE KNOWLEDGE AND ACCESS TO NO-COST RAPE TEST KITS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-80.999

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 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.
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.

212. MARIJUANA PRODUCT SAFETY
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-95.969, H-95.952, H-95.924, AND H-95.936 BE REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

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; 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.

213. TELEMEDICINE SERVICES AND HEALTH EQUITY
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
REAFFIRMED POLICIES H-480.937 AND H-480.946
See Policy H-480.936

RESOLVED, That our AMA encourage policymakers to recognize 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.

214. ADVOCACY AND ACTION FOR A SUSTAINABLE MEDICAL CARE SYSTEM
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 214 ADOPTED
IN LIEU OF RESOLUTIONS 214, 234, AND 257
See Policy D-385.945, 390.922, H-390.849 and D-390.946

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.

215. SUPPORTING LEGISLATIVE AND REGULATORY EFFORTS AGAINST FERTILITY FRAUD
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES H-140.900 AND B-1.1.1 BE REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

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; 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.

216. IMPROVED FOSTER CARE SERVICES FOR CHILDREN
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-60.897

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

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 for at-risk families in an effort to prevent family separation; 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; 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; and be it further

RESOLVED, That our AMA 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.

217. INCREASE ACCESS TO SAFE AND EFFECTIVE OVERDOSE REVERSAL MEDICATIONS IN EDUCATIONAL SETTINGS
Introduced by American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association, American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-95.908

RESOLVED, that our AMA encourage states, communities, and educational settings, to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications naloxone readily accessible to staff and teachers to prevent opioid overdose deaths in educational settings; and be it further

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

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

218. PROMOTING SUPERVISION OF EMERGENCY CARE SERVICES IN EMERGENCY DEPARTMENTS BY PHYSICIANS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-35.976

RESOLVED, That our American Medical Association advocate for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an emergency department.

219. PHYSICIAN-OWNED HOSPITALS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTIONS 222 AND 261
TITLE CHANGED
See Policy D-215.983

RESOLVED, That our American Medical Association advocate for policies that remove restrictions upon physicians from owning, constructing, and/or expanding any hospital facility type; and be it further

RESOLVED, That our AMA study and research the impact of the repeal of the ban on physician-owned hospitals on the access to, cost, and quality of, patient care, and their impact on competition in highly concentrated hospital markets; 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 to develop and promote policies that support physician ownership of hospitals.

220. COVERAGE OF ROUTINE COSTS IN CLINICAL TRIALS BY MEDICARE ADVANTAGE ORGANIZATIONS

Introduced by Connecticut; Maine; Massachusetts; New Hampshire; Rhode Island; Vermont; Maryland; American College of Radiation Oncology; American Society for Radiation Oncology; American Society of Clinical Oncology; Association of University Radiologists

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-460.882

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.

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

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.

221. FENTANYL TEST STRIPS AS A HARM REDUCTION AND OVERDOSE PREVENTION TOOL

Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-95.987

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.
3~~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.
4~~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.
5~~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.
6~~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.
7~~6~~. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction by supporting legalization of, and education and training on, the use of FTS.

222. PHYSICIAN OWNERSHIP OF HOSPITAL BLOCKED BY THE ACA
Introduced by Pennsylvania

Resolution 222 was considered with Resolution 219 and 261.
See Resolution 219, which was adopted in lieu of Resolution 222 and 261.

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.

223. PROTECTING ACCESS TO GENDER AFFIRMING CARE
Introduced by The Endocrine Society, American Association of Clinical Endocrinology, American Society for Reproductive Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-185.927

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

Clarification of ~~Medical Necessity~~ 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.~~

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.

224. ADVOCACY AGAINST OBESITY-RELATED BIAS BY INSURANCE PROVIDERS
Introduced by American Society for Metabolic and Bariatric Surgery and Society of American Gastrointestinal and Endoscopic Surgeons

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-440.801

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; 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.

225. REGULATION OF "COOL/NON-MENTHOL" TOBACCO PRODUCTS
Introduced by American Thoracic Society

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-495.970

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.

226. VISION QUALIFICATIONS FOR DRIVER'S LICENSE
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-425.965

RESOLVED, That our American Medical Association support efforts to standardized vision requirements for unrestricted and restricted driver's licensing privileges.

227. REIMBURSEMENT FOR POSTPARTUM DEPRESSION PREVENTION
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-420.953

RESOLVED, That our American Medical Association amend Policy H-420.953, "Improving Mental Health Services for Pregnant and Postpartum Mothers," by addition and deletion to read as follows:

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 or in a postpartum state.

228. REDUCING STIGMA FOR TREATMENT OF SUBSTANCE USE DISORDER
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICY D-95.968 ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 228

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
4. Our AMA supports increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders.

229. FIREARM REGULATION FOR PERSONS CHARGED WITH OR CONVICTED OF A VIOLENT OFFENSE
Introduced by Michigan

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-515.979 AND H-145.997 REAFFIRMED
IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association study the effect of including a rescindment period of 10 years for the possession of a firearm by persons convicted of a violent offense in accordance with other established rescindment periods adopted by other states.

230. ADDRESS DISPROPORTIONATE SENTENCING FOR DRUG OFFENSES
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-95.907

RESOLVED, That our American Medical Association support federal and state efforts to eliminate the national crack and powder cocaine sentencing disparity (from 18:1 to 1:1) and apply them retroactively to those already convicted or sentenced

231. - EQUITABLE INTERPRETER SERVICES AND FAIR REIMBURSEMENT
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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; 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.

232. SUPERVISED INJECTION FACILITIES (SIFS) ALLOWED BY FEDERAL LAW
Introduced by Minnesota

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-95.925 REAFFIRMED IN LIEU OF RESOLUTION 232

RESOLVED, That our American Medical Association amend policy H-95.925, "*Pilot Implementation of Supervised Injection Facilities,"* by addition to read as follows:

Pilot Implementation of Supervised Injection Facilities H-95.925
"Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use, including supporting changes to federal law to permit the operation of pilot SIFs in the United States. Until federal law permits the operation of pilot SIFs in the United States, our AMA will regularly pursue explicit commitments from each active presidential administration that federal lawsuits will not be filed against operators of pilot SIFs.

233. DOBBS – EMTALA MEDICAL EMERGENCY
Introduced by Missouri

Considered on reaffirmation calendar.

HOD ACTION: POLICY D-160.911, D-5.998, AND D-5.999 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for policies to ensure that all patients receive prompt, complete and unbiased emergency health care that is medically sound and evidence-based, in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

234. MEDICARE PHYSICIAN FEE SCHEDULE UPDATES AND GRASSROOTS CAMPAIGN
Introduced by American Academy of Dermatology, Pennsylvania, The American Society of Dermatopathology, Society for Investigative Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery

Resolution 234 was considered with Resolution 214 and 257.
See Resolution 214, which was adopted in lieu of 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; 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; 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.

235. EMS AS AN ESSENTIAL SERVICE
Introduced by American College of Emergency Physicians

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-130.930

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; 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.

236. AMA SUPPORT FOR NUTRITION RESEARCH
Introduced by American College of Cardiology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-150.921

RESOLVED, That our American Medical Association support additional funding for National Institutes of Health's (NIH's) Office of Nutrition Research (ONR) to enable ONR to secure the leadership, organizational structure, and resources to effectively fulfill its important mission; and be it further

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.

237. PROHIBITING COVENANTS NOT-TO-COMPETE IN PHYSICIAN CONTRACTS
Introduced by California, American Academy of Family Physicians, American Association of Neurological Surgeons, American College of Surgeons, Congress of Neurological Surgeons, The Society of Thoracic Surgeons

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: RESOLUTION 237 ADOPTED
IN LIEU OF RESOLUTION 263
See Policy H-265.988

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; 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; 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.

238. ELIMINATE MANDATORY MEDICARE BUDGET CUTS
Introduced by Arizona

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-390.849 AND D-390.946 REAFFIRMED
IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association continue to advocate for new legislation on Medicare physician payment reform.

239. PHYSICIAN ASSISTANT AND NURSE PRACTITIONER MOVEMENT BETWEEN SPECIALTIES

Introduced by Arizona

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 262
TITLE CHANGED
See Policy D-35.975

RESOLVED, That our American Medical Association study the movement of nonphysician health care professionals, such as physician assistants and nurse practitioners, between specialties.

240. ATTORNEYS' RETENTION OF CONFIDENTIAL MEDICAL RECORDS AND CONTROLLED MEDICAL EXPERT'S TAX RETURNS AFTER CASE ADJUDICATION

Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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; 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.

241. ALLOW VIEWING ACCESS TO PRESCRIPTION DRUG MONITORING PROGRAMS THROUGH EHR FOR CLINICAL MEDICAL STUDENTS AND RESIDENTS

Introduced by Illinois

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-95.945

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.

242. PEER TO PEER REVIEWER MUST BE OF SAME SPECIALTY AS PHYSICIAN REQUESTING PROCEDURE

Introduced by Illinois

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-285.998 REAFFIRMED
IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association adopt policy in support of and cause to be introduced legislation requiring any peer to peer review require a physician from the same specialty as the physician requesting a procedure for their patient, be involved in the peer to peer phone call and decision process.

243. REPLACING THE FRYE STANDARD FOR THE DAUBERT STANDARD IN EXPERT WITNESS TESTIMONY
Introduced by Illinois

Considered on reaffirmation calendar.

HOD ACTION: POLICY 9.7.1 REAFFIRMED
IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate through legislative or other relevant means the use of the Daubert Standard to replace the Frye Standard for Expert Witness Testimony.

244. IMPROVING CARE TO LOWER THE RATE OF RECIDIVISM
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS AND
POLICY H-430.986(2) ADOPTED AS FOLLOWS
TITLE CHANGED
See Policies H-430.978 and H-430-986

RESOLVED, That our American Medical Association advocate and encourage federal, state, and local legislators and officials to increase access to 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; 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.

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.

245. BIOSIMILAR/ INTERCHANGEABLE TERMINOLOGY
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, That our American Medical Association rescind repeal policy H-125.976, Biosimilar Interchangeability Pathway; and be it further

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.

246. MODIFICATION OF CMS INTERPRETATION OF STARK LAW
Introduced by Association for Clinical Oncology and American College of Rheumatology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy H-385.902

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; 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.

247. ASSESSING THE POTENTIALLY DANGEROUS INTERSECTION BETWEEN AI AND MISINFORMATION

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 247 ADOPTED
IN LIEU OF RESOLUTIONS 251 AND 256
See Policy H-480.935

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; 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; 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.

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.

248. SUPERVISED CONSUMPTION SITES
Introduced by Indiana

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-95.925 REAFFIRMED
IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek information and consider policy and legislation regarding the federal legalization of overdose prevention sites; and be it further

RESOLVED, That our AMA amend policy H-95.925, Pilot Implementation of Supervised Injection Facilities, to replace the references to “supervised injection facilities” with “overdose prevention sites”.

249. RESTRICTIONS ON SOCIAL MEDIA PROMOTION OF DRUGS
Introduced by Indiana

Considered on reaffirmation calendar.

HOD ACTION: POLICY D-478.965, D-440.915, D-95.987 AND H-105.988 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek policy and legislation that would limit social media's promotion and dissemination of corporate advertisement on usage of commercial and illicit drugs to our youth.

250. MEDICARE BUDGET NEUTRALITY
Introduced by Indiana

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-390.849 AND D-390.946 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association reaffirm its position supporting removal of budget neutrality for Medicare physician payments, which would result in regular positive updates for physicians so that the payments can keep up with inflation and practice expenses.

251. FEDERAL GOVERNMENT OVERSIGHT OF AUGMENTED INTELLIGENCE
Introduced by Maryland

Resolution 251 was considered with Resolutions 247 and 256.
See Resolution 247, which was adopted in lieu of Resolutions 251 and 256.

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.

252. STRENGTHENING PATIENT PRIVACY
Introduced by Maryland

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-315.983, D-315.968 AND H-480.943 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association study the modern threats to patient privacy, especially in the context of augmented intelligence, and generate recommendations to guide AMA advocacy in this area for the betterment of patient rights.

253. APPROPRIATE COMPENSATION FOR NON-VISIT CARE (REMOTE OR CARE OF COORDINATION)
Introduced by New York

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-480.937 AND D-480.962 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association create a policy stating that payors should compensate physicians for asynchronous (outside the day of a patient visit) non-visit or remote care, such phone calls, electronic messaging, and review of laboratory data; and be it further

RESOLVED, That our AMA advocate for expansion of Current Procedural Terminology (CPT) codes 99441-99445 into telemedicine parity law, that will include reimbursement similar to other CPT codes.

254. ELIMINATING THE PARTY STATEMENT EXCEPTION IN QUALITY ASSURANCE PROCEEDING
Introduced by American College of Surgeons, American Academy of Otolaryngology – Head and Neck Surgery, American Academy of Orthopaedic Surgeons, American Academy of Ophthalmology, American Society of Plastic Surgeons

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policies H-450.923

RESOLVED, That our American Medical Association reaffirm the importance of meaningful Quality Assurance proceedings that are unhindered by legal discovery concerns; 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.

RESOLUTION 255 WAS REASSIGNED AS RESOLTION 432

256. REGULATING MISLEADING AI GENERATED ADVICE TO PATIENTS
Introduced by American Society for Surgery of the Hand, American Association of Hand Surgery

Resolution 256 was considered with Resolutions 247 and 251.
See Resolution 247, which was adopted in lieu of Resolutions 251 and 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; 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; 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.

257. AMA EFFORTS ON MEDICARE PAYMENT REFORM
Introduced by Texas, Florida, Pennsylvania, American Academy of Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery Association, Arizona, California, Indiana, Mississippi, New Jersey, New York, Oklahoma, South Carolina

Resolution 257 was considered with Resolution 214 and 234.
See Resolution 214, which was adopted in lieu of Resolution 257.

RESOLVED, That our American Medical Association 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 our AMA make the next National Advocacy Conference 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 report back to the House of Delegates at each annual and interim session on the progress of our AMA staff and physicians until this goal is accomplished.

258. ADJUSTMENTS TO HOSPICE DEMENTIA ENROLLMENT CRITERIA
Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, That our 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.

259. STRENGTHENING SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
POLICIES H-150.937 AND D-440.927 BE REAFFIRMED
See Policies H-150.920, H-150.937 and D-440.927

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

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

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"
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES H-405.968 AND H-405.951 BE 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; 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; 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".

261. PHYSICIAN OWNED HOSPITALS
Introduced by Private Practice Physicians Section

Resolution 261 was considered with Resolution 219 and 222.
See Resolution 219, which was adopted in lieu of Resolution 222 and 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; and be it further

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA 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 AMA 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; and be it further

RESOLVED, That our AMA 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.

262. ALIGNMENT OF SPECIALTY DESIGNATIONS FOR ADVANCED PRACTICE PROVIDERS WITH THEIR SUPERVISING PHYSICIANS

Introduced by Private Practice Physicians Section

Resolution 262 was considered with Resolution 239.
See Resolution 239, which was adopted in lieu of Resolution 262.

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; and be it further

RESOLVED, That our AMA study and report back at Interim 2023 on the economic impact to medical practices of specialty switching by advanced practice providers; and be it further

RESOLVED, That our AMA 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

263. ELIMINATION OF NON-COMPETE CLAUSES IN EMPLOYMENT CONTRACTS

Introduced by Resident and Fellow Section

Resolution 263 was considered with Resolution 237.
See Resolution 237, which was adopted in lieu of 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

REFERENCE COMMITTEE C

301. TEACHING AND ASSESSING OSTEOPATHIC MANIPULATIVE MEDICINE AND OSTEOPATHIC PRINCIPLES AND PRACTICE

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ALTERNATE RESOLUTION 301 ADOPTED IN LIEU OF RESOLUTIONS 301 AND 310
See Policy H-295.848

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; and be it further

RESOLVED, That our AMA encourage physician awareness of the benefits of evidence-based Osteopathic Manipulative Medicine for musculoskeletal conditions; 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.

302. STUDY OF THE CURRENT MATCH PROCESS AND ALTERNATIVES
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED TITLE CHANGED
See Policy D-310.944

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.

303. MEDICAL SCHOOL MANAGEMENT OF UNMATCHED MEDICAL STUDENTS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: 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.

304. INCREASING ACCESS TO GENDER-AFFIRMING CARE THROUGH EXPANDED TRAINING AND EQUITABLE COVERAGE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED AS FOLLOWS**
TITLE CHANGED
See Policy H-295.847 and H185.927

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

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

305. INDIAN HEALTH SERVICE GRADUATE MEDICAL EDUCATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy 350.977

RESOLVED, That our American Medical Association 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; and be it further

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

306. INCREASED EDUCATION AND ACCESS TO FERTILITY RESOURCES FOR U.S. MEDICAL STUDENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-295.846

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA 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.

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
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-295.858

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 education programs to create mental health ~~and~~ substance ~~ab~~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.
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.

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

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ALTERNATE RESOLUTION 308 ADOPTED IN LIEU OF RESOLUTION 308
See Policy D-295.302

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.

309. AGAINST LEGACY PREFERENCES AS A FACTOR IN MEDICAL SCHOOL ADMISSIONS

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ALTERNATE RESOLUTION 309 ADOPTED IN LIEU OF RESOLUTION 309
See Policy H-295.845

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, but oppose the use of questions about legacy status in their medical school application process due to their discriminatory impact.

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

Introduced by Medical Student Section

Resolution 310 was considered with Resolution 301.
See Resolution 301, which was adopted in lieu of Resolution 210.

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.

311. RESIDENCY APPLICATION SUPPORT FOR STUDENTS OF LOW-INCOME BACKGROUNDS

Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-305.925

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.

312. INDIAN HEALTH SERVICE LICENSING EXEMPTIONS

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ALTERNATE RESOLUTION 312ADOPTED
IN LIEU OF RESOLUTION 312
See Policy H-270.950

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.

313. FILTERING INTERNATIONAL MEDICAL GRADUATES DURING RESIDENCY OR FELLOWSHIP APPLICATIONS

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ALTERNATE RESOLUTION 312ADOPTED
IN LIEU OF RESOLUTION 312 AND 315
See Policy H-255.963

RESOLVED, That our AMA recognize the exclusion of certain residency applicants from consideration, such as international medical graduates; 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.

314. SUPPORT FOR INTERNATIONAL MEDICAL GRADUATES FROM COUNTRIES FACING MAJOR HUMANITARIAN CRISES
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-255.962

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; 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.

315. PROHIBIT DISCRIMINATORY ERAS® FILTERS IN NRMP MATCH
Introduced by Michigan

Resolution 315 was considered with Resolution 313.
See Resolution 313, which was adopted in lieu of 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.

316. PHYSICIAN MEDICAL CONDITIONS AND QUESTIONS ON APPLICATIONS FOR MEDICAL LICENSURE, SPECIALTY BOARDS, AND INSTITUTIONAL PRIVILEGES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-275.970

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 their ~~his/her~~ judgment or that would otherwise adversely affect their ~~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.

317. SUPPORTING CHILDCARE FOR MEDICAL RESIDENTS
Introduced by Illinois

Considered on reaffirmation calendar.

HOD ACTION: POLICY D-200.974 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association reaffirm Policy D-200.974, Supporting Child Care for Health Care Professionals, committing to investigate barriers to childcare for medical trainees, as well as innovative childcare methods.

318. FOSTERING PATHWAYS FOR RESIDENT PHYSICIANS TO PURSUE MBA PROGRAMS IN ORDER TO INCREASE THE NUMBER OF QUALIFIED PHYSICIANS FOR HEALTHCARE LEADERSHIP POSITIONS
Introduced by Illinois

Resolution 318 was considered with Council on Medical Education Report 7.
See Council on Medical Education Report 7, which was adopted in lieu of 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.

319. SUPPORTING DIVERSITY, EQUITY, & INCLUSION OFFICES AND INITIATIVES AT UNITED STATES MEDICAL SCHOOLS TO ENHANCE LONGITUDINAL COMMUNITY ENGAGEMENT
Introduced by Minority Affairs Section, National Medical Association

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-295.963

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

320. BANNING AFFIRMATIVE ACTION IS A CRITICAL THREAT TO HEALTH EQUITY AND TO THE MEDICAL PROFESSION

Introduced by Minority Affairs Section, National Medical Association

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED
See Policies D-200.985 and H-350.979

RESOLVED, That our American Medical Association amend H-350.979, Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession, by deletion and addition to read as follows:

> (3) urging medical school and undergraduate admissions committees to c~~onsider minority representation as one factor in reaching their decisions~~ proactively implement policies and procedures that operationalize race-conscious admission practices in admissions decisions, among other factors; and be it further

RESOLVED, That our AMA amend D-200.985, Strategies for Enhancing Diversity in the Physician Workforce, by deletion and addition to read as follows:

> (12) unequivocally opposes legislation that would ~~undermine institutions' ability to properly employ~~ dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population; and be it further

RESOLVED, That our AMA recognize the consideration of race in admissions is a necessary safeguard in creating a pipeline to an environment within medical education that will propagate the advancement of health equity through diversification of the physician workforce.

321. CORPORATE COMPLIANCE CONSOLIDATION
Introduced by New York

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-300.944

RESOLVED, That our AMA encourage reciprocity for corporate compliance curricula between institutions to minimize duplicate training and assessment of physicians

322. DISCLOSURE OF COMPLIANCE ISSUES RELATED TO JOINT PROVIDERSHIP
Introduced by New York

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-300.974

RESOLVED, That 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; and be it further

323. AMEND POLICY D-275.948, "EDUCATION, TRAINING AND CREDENTIALING OF NON-PHYSICIAN HEALTH CARE PROFESSIONALS AND THEIR IMPACT ON PHYSICIAN EDUCATION AND TRAINING"
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-275.948

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~~ 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.

REFERENCE COMMITTEE D

401. METERED DOSE INHALERS AND GREENHOUSE GAS EMISSIONS

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ALTERNATE RESOLUTION 401 ADOPTED IN LIEU OF RESOLUTION 401
See Policy H-135.913

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.

402. ENCOURAGING DISCUSSION OF FAMILY PLANNING COUNSELING AS PART OF RECOMMENDED ROUTINE HEALTH MAINTENANCE
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See policy H-425.976

RESOLVED, That our American Medical Association work with interested parties to encourage discussion of family planning counseling with all individuals with reproductive potential as part of routine health maintenance.

403. DENOUNCING THE USE OF SOLITARY CONFINEMENT IN CORRECTIONAL FACILITIES AND DETENTION CENTERS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-430.983

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 for medical reasons is acceptable ~~except for medical isolation or~~ to protect individuals who are at imminent risk or are actively being harmed by themselves or are at imminent risk of or actively being ~~will be immediately~~ harmed by a physically violent individual, in which cases ~~medical~~ isolation for medical reasons may be used for as short a time as possible; ~~and~~ (~~2~~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 (~~3~~4) encourage appropriate parties 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.~~

404. ADDITIONAL INTERVENTIONS TO PREVENT HUMAN PAPILLOMAVIRUS (HPV) INFECTION AND HPV-ASSOCIATED CANCERS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: REFERRED FOR DECISION

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 interested parties to make available human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers; 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:

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 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~~ 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 the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies to ensure coverage is consistent with current evidence-based guidelines.

RESOLVED, That our AMA support further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening.

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
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **REAFFIRM POLICY H-145.975 IN LIEU OF RESOLVE 1 ADOPTED RESOLVE 2 AND 3 AS FOLLOWS**
See Policy TBD

RESOLVED, That our AMA work with relevant parties to update medical curricula and physician training regarding how to approach conversations with patients and families and to utilize Extreme Risk Protection Orders; 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, 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, 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.

406. INCREASE EMPLOYMENT SERVICES FUNDING FOR PEOPLE WITH DISABILITIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED**
See Policy H-90.964

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

407. ADDRESSING INEQUITY IN ONSITE WASTEWATER TREATMENT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-135.912

RESOLVED, That our American Medical Association 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, especially in underserved communities and American Indian; 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.

RESOLVED, That our AMA work with interested parties to reduce and eliminate inadequate wastewater treatment systems.

408. SCHOOL-TO-PRISON PIPELINE
Introduced by Medical Student Section

Resolution 408 was considered with Council on Science and Public Health Report 4.
See Council on Science and Public Health Report 4, which was adopted in lieu of Resolution 408.

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.

409. EXPANDING INCLUSION OF DIVERSE MANNEQUINS USED IN CPR AND AED TRAINING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: 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; 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; 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

410. FORMAL TRANSITIONAL CARE PROGRAM FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-60.974

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.

411. PROTECTING WORKERS DURING CATASTROPHES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-365.995

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; 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 parties develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment during catastrophes.

412. MEDICAL WASTE RECEPTACLES IN ALL RESTROOM STALLS

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ALTERNATE RESOLUTION 412 ADOPTED
IN LIEU OF RESOLUTION 412
See Policy D-65.980

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.

413. SUPPORTING SAFE LEAVE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy H-420.979

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; 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, 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 violence, including 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.

414. INCREASED ACCESS TO HIV TREATMENT AND SUPPORTIVE SERVICES IN THE UNSTABLY HOUSED AND HOMELESS POPULATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-20.922

RESOLVED, That our American Medical Association support policies that promote stable housing for and encourage retention of homeless patients in HIV/AIDS treatment programs.

RESOLVED, That our AMA recognize that stable housing promotes adherence to HIV treatment; 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.

415. ENVIRONMENTAL HEALTH EQUITY IN FEDERALLY SUBSIDIZED HOUSING
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-135.911 and D-135.997

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; and be it further

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; 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; and be it further

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

D-135.997 – ~~RESEARCH INTO THE~~ ENVIRONMENTAL CONTRIBUTORS TO DISEASE AND ADVOCATING FOR ENVIRONMENTAL JUSTICE
Our AMA will (1) advocate for the greater public and private funding for research into the environment causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as ~~a~~

priority public health issues; (3) encourage federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (~~3~~4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

416. NEW POLICIES TO RESPOND TO THE GUN VIOLENCE PUBLIC HEALTH CRISIS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-145.996

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; 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; and be it further

RESOLVED, That our AMA advocate for federal and state policies implementing background checks for ammunition purchases.

417. TREATING SOCIAL ISOLATION AND LONELINESS AS A SOCIAL DRIVER OF HEALTH
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-440.913

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; and be it further

RESOLVED, That our AMA promote enhancing access, including transportation, to health and social services; 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; and be it further

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; 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.

418. INCREASING THE AVAILABILITY OF AUTOMATED EXTERNAL DEFIBRILLATORS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-130.938

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.

419. INCREASED SUICIDE RISK FOR CHILDREN, YOUTHS, AND YOUNG ADULTS IN THE WELFARE SYSTEM
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee D

HOD ACTION: ADOPTED
See Policy H-60.937

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.

420. FOSTER HEALTH CARE
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-60.910

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.

421. PRESCRIBING GUIDED PHYSICAL ACTIVITY FOR DEPRESSION AND ANXIETY
Introduced by American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-470.997

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.

422. ADVOCATE FOR A NATIONAL EMERGENCY FOR CHILDREN'S MENTAL HEALTH

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ALTERNATE RESOLUTION 422 ADOPTED IN LIEU OF RESOLTUION 422
See Policy D-345.972

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.

423. REDUCING SODIUM INTAKE TO IMPROVE PUBLIC HEALTH
Introduced by Connecticut; Maine; Massachusetts; New Hampshire; Rhode Island; Vermont

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: 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; 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.

424. JOB SECURITY RELATED TO LEAVE FOR CAREGIVER WHEN A CHILD IN FOSTER CARE IS PLACED IN THEIR HOME
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy TBD

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.

425. PROMOTING STANDARDIZATION OF DEATH CERTIFICATION FOR IN-CUSTODY DEATHS
Introduced by Minnesota

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-65.987

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.; 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 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.

426. ACCURATE ABORTION REPORTING WITH DEMOGRAPHICS BY THE CENTER FOR DISEASE CONTROL
Introduced by Dr. Thomas W. Eppes, MD, Delegate

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: 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.

427. MINIMIZING THE INFLUENCE OF SOCIAL MEDIA ON GUN VIOLENCE
Introduced by Delaware

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-478.977

RESOLVED, That our American Medical Association call upon all social media sites 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; 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; 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.

428. MATTRESS SAFETY IN THE HOSPITAL SETTING
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-440.799

RESOLVED, That our American Medical Association work with the accrediting bodies, health care professional organizations, and interested parties to make sure all possible appropriate care and maintenance measures be undertaken to mitigate infection related to hospital bed and mattress use.

429. PROMOTING THE HIGHEST QUALITY OF HEALTHCARE AND OVERSIGHT FOR THOSE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: **ADOPTED AS FOLLOWS**
See Policy H-430.986

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:

1. MD or DO, 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, 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

RESOLVED, That the AMA collaborate with 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

430. TEENS AND SOCIAL MEDIA
Introduced by Albert L. Hsu, MD, Delegate

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-478.976

RESOLVED, That our American Medical Association study and make recommendations for teenage use of social media, including proposing model state and federal legislation as needed, with a report back at the 2024 Annual Meeting.

431. QUALIFIED IMMUNITY REFORM
Introduced by Minority Affairs Section, National Medical Association

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-65.954

RESOLVED, That our American Medical Association recognize the way we police our communities is a social determinant of health; 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; and be it further

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.

432. CORRECTIONAL MEDICINE
Introduced by Georgia

Resolution 432 was considered with Council on Science and Public Health Report 6.
See Council on Science and Public Health Report 6, which was adopted in lieu of Resolution 432.

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.

433. UPHOLDING SCIENTIFICALLY AND MEDICALLY VALID PRACTICES FOR BLOOD TRANSFUSIONS
Introduced by Texas

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-50.995

RESOLVED, That our American Medical Association support scientifically and medically supported transfusion best practices; and be it further

RESOLVED, That our 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; and be it further

RESOLVED, That AMA oppose all legislation or policy mandating that blood banks accommodate all directed donor requests.

434. IMPROVING HAZARDOUS CHEMICAL TRANSPORT REGULATIONS FOR PUBLIC HEALTH PROTECTIONS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-135.993

RESOLVED, That our American Medical Association amend H-135.993 by addition and deletion 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.

435. STAND YOUR GROUND LAWS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-145.966

RESOLVED, That our American Medical Association study the public health implications of "Stand Your Ground" laws and castle doctrine.

436. PREDIABETES AS A MAJOR HEALTH CONCERN FOR CHRONIC DISEASE PREVENTION
Introduced by American College of Preventive Medicine

Reference committee hearing: see report of Reference Committee D.

HOD ACTION: ADOPTED
See Policy H-440.798

RESOLVED, That our American Medical Association acknowledge prediabetes as a major health concern for chronic disease prevention in the United States and support 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

REFERENCE COMMITTEE E

501. AMA STUDY OF CHEMICAL CASTRATION IN INCARCERATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED
See Policy H-430.977

RESOLVED, That our American Medical Association study the use of chemical castration in the treatment of incarcerated individuals with paraphilic disorders and for other individuals who commit sexual offenses, including ethical concerns over coercion in its use as an alternative to incarceration and in probation and parole proceedings.

502. PAIN MANAGEMENT FOR LONG-ACTING REVERSIBLE CONTRACEPTION AND OTHER GYNECOLOGICAL PROCEDURES
Introduced by Medial Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-75.983

RESOLVED, That our AMA recognizes that disproportionate care 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; 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.

Our AMA shall advocate for equitable insurance coverage for the placement of long-acting reversible contraceptives and other gynecological procedures, including associated pain management.

503. INCREASING DIVERSITY IN STEM CELL BIOBANKS AND DISEASE MODELS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-460.881 and H-460.915

RESOLVED, That our AMA encourages research institutions and stakeholders to re-evaluate recruitment strategies and materials to encourage participation by underrepresented populations; 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 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

RESOLVED, That our AMA strongly encourages institutional biobanks to collect samples diverse with respect to race, ethnicity, and genetic ancestry, such that future induced pluripotent stem cell disease models better represent the population.

RESOLUTION 504 WAS REASSIGNED AS RESOLTION 256

505. DE-STIGMATIZATION AND MANAGEMENT OF SUBSTANCE USE DISORDERS

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ALTERNATE RESOLUTION 505 ADOPTED IN LIEU OF RESOLUTION 505 AND 525
See Policies H-95.906, H-95.932, D-95.987 and H-420.950

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) 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.; 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.; 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 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.; 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.

RESOLUTION 506 WAS REASSIGNED AS RESOLTION 609

507. RECOGNIZING THE BURDEN OF RARE DISEASE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See policy H-460.880

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; 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 and medical device companies to develop novel therapeutics and devices to better understand and treat orphan diseases; and be it further

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.

508. DEVELOPMENT AND IMPLEMENTATION OF RECOMMENDATIONS FOR RESPONSIBLE MEDIA COVERAGE OF OPIOID OVERDOSES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See H-95.905

RESOLVED, That our American Medical Association encourage the Centers for Disease Control and Prevention, in collaboration with other public and private 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.

509. MEDICAL AND PUBLIC HEALTH MISINFORMATION ONLINE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED
TITLE CHANGED
See Policy D-440.915

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

510. COMPARATIVE EFFECTIVENESS RESEARCH
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED
See Policy H-450.922

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; 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.

511. REGULATION OF PHTHALATES IN ADULT PERSONAL SEXUAL PRODUCTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED
See Policy H-135.945

RESOLVED, That our American Medical Association amend policy H-135.945 by addition and deletion to read as follows:

Encouraging Alternatives to PVC/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.

512. WHEELCHAIRS ON AIRPLANES

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ALTERNATE RESOLUTION 512 ADOPTED IN LIEU OF RESOLUTION 512
See Policy H-90.963

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.

513. SUBSTANCE USE HISTORY IS MEDICAL HISTORY
Introduced by American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association, American Academy of Addiction Psychiatry, American Society of Addiction Psychiatry

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-95.904

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; 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; and be it further

RESOLVED, That our AMA work with relevant parties, 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.

514. HALLUCINOGEN-ASSISTED THERAPY POLICY
Introduced by American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association, American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS TITLE CHANGED
See Policy H-100.943

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 inwithin the context of approved investigational studies; 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.

515. REGULATION AND STUDY OF KRATOM

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ALTERNATE RESOLUTION 515 ADOPTED IN LIEU OF RESOLUTION 515
See Policy H-95.903

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 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.

RESOLVED, That Policy H-95.934, Kratom and Its Growing Use Within the United States, be rescinded.

516. FASTING IS NOT REQUIRED FOR ALL LIPID ANALYSIS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-425.964

RESOLVED, That our American Medical Association support the development of educational programs affirming that fasting is not required for routine screening via lipid analysis.

517. HEALTHCARE DISPARITIES, INCLUDING CARDIOVASCULAR DISEASE, IN SOUTH ASIANS RESIDING IN THE UNITED STATES
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-350.947

RESOLVED, that our AMA support and advocate for additional NIH funding to study disparities in population health which lead to diseases with high morbidity such as cardiovascular disease in South Asian patients; and be it further

RESOLVED, that our AMA encourage the development of collaborative partnerships with other organizations, institutions, policymakers, and interested parties to reduce health disparities and any accompanying cultural and linguistic barriers, through the creation of educational campaigns and outreach programs.

518. DEFENDING NIH FUNDING OF ANIMAL MODEL RESEARCH FROM LEGAL CHALLENGES
Introduced by American Thoracic Society

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: POLICIES H-460.979, H-460.957, H-460.932, H-460.953, AND H-460.964 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

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.

519. DECREASING REGULATORY BARRIERS TO APPROPRIATE TESTOSTERONE PRESCRIBING

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ALTERNATE RESOLUTION 519 ADOPTED
IN LIEU OF RESOLUTION 519
SECOND RESOLVE OF ALTERNATE 519 REFERRED
See Policy D-270.983

RESOLVED, That the AMA ask the FDA to review the available evidence and other data on testosterone and submit updated recommendations, if warranted, to the DEA, for its consideration of the scheduling of testosterone-containing drug products; and be it further

[Editor's note: the following Resolve referred]

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.

520. SUPPORTING ACCESS TO AT-HOME INJECTABLE CONTRACEPTIVES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED
See Policy H-75.982

RESOLVED, That our American Medical Association support access to at-home contraceptive injections as a method of birth control for women across the nation.

521. PREVENTING THE ELIMINATION OF CANNABIS FROM OCCUPATIONAL AND MUNICIPAL DRUG TESTING PROGRAMS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-95.902

RESOLVED, That our American Medical Association support the continued inclusion of cannabis metabolite analysis in relevant drug testing analysis performed for occupational and municipal purposes (pre-employment, post-accident, random and for-cause).

522. APPROVAL AUTHORITY OF THE FDA
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee E.

HOD ACTION: POLICIES H-100.948 AND H-100.992 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

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.

523. REDUCING YOUTH ABUSE OF DEXTROMETHORPHAN
Introduced by Indiana

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-95.978 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association seek and support methods to reduce the sale of products containing dextromethorphan to minors.

524. ENSURING ACCESS TO REPRODUCTIVE HEALTH SERVICES MEDICATIONS
Introduced by New York

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-100.948, H-100.992 AND H-100.980 REAFFIRMED IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate and support the continuation of the Food and Drug Administration's authority to determine whether drugs are safe and effective; and be it further

RESOLVED, That our AMA support legal efforts to ensure that mifepristone and misoprostol are available to anyone for whom they are prescribed; and be it further

RESOLVED, That our AMA support efforts, including joining in an Amicus Brief, to ensure that both these medications continue to be available, and that the FDA retain its regulatory authority.

525. DECRIMINALIZING AND DESTIGMATIZING PERINATAL SUBSTANCE USE TREATMENT
Introduced by Resident and Fellow Section

Resolution 525 was considered with Resolutions 505.
See Resolution 505, which was adopted in lieu of Resolution 525.

RESOLVED, That our American Medical Association 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.

REFERENCE COMMITTEE F

601. SOLICITATION USING THE AMA BRAND
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: 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; 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.

602. SUPPORTING THE USE OF GENDER-NEUTRAL LANGUAGE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-65.942

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) 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.

603. ENVIRONMENTAL SUSTAINABILITY OF AMA NATIONAL MEETINGS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: REFERRED

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; 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; 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; 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.

604. SPEAKERS TASK FORCE TO REVIEW AND MODERNIZE THE RESOLUTION PROCESS
Introduced by American Academy of Physical Medicine and Rehabilitation

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED
See Policy G-600.045

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; 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.

605. EQUITY AND JUSTICE INITIATIVES FOR INTERNATIONAL MEDICAL GRADUATES
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: 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; 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.

606. AMA REIMBURSEMENT OF NECESSARY HOD BUSINESS MEETING EXPENSES FOR DELEGATES AND ALTERNATE DELEGATES
Introduced by Georgia, Mississippi, Oklahoma, New Jersey, Alabama, Virginia, Delaware

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: 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; 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.

607. ENABLING SECTIONS OF THE AMERICAN MEDICAL ASSOCIATION
Introduced by Matthew D. Gold, M.D., Delegate

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy G-615.999

RESOLVED, That our American Medical Association Sections will be given an option to meet officially over no less than two calendar days in anticipation of general House of Delegates meetings unless otherwise determined by a given individual Section.

608. SUPPORTING CARBON OFFSET PROGRAMS FOR TRAVEL FOR AMA CONFERENCES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: REFERRED

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.

609. ENCOURAGING COLLABORATION BETWEEN PHYSICIANS AND INDUSTRY IN AI (AUGMENTED INTELLIGENCE) DEVELOPMENT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: 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; 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.

610. NIH PUBLIC ACCESS PLAN

Introduced by American College of Rheumatology, American Academy of Allergy, Asthma and Immunology, American Academy of Neurology, American College of Physicians, American Society of Anesthesiologists, American Society of Hematology, American Society for Radiation Oncology, American Thoracic Society, American Urological Association, Association for Clinical Oncology, Endocrine Society

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED
See Policy D-460.977

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.

REFERENCE COMMITTEE G

701. RECONSIDERATION OF THE BIRTHDAY RULE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy H-185.913 and H-190.969

RESOLVED, That our American Medical Association support evidence-based legislation that support a parent, or guardian's, choice of their dependent's health insurance plan under the event of multiple insurers; and be it further

RESOLVED, That our AMA amend Policy H-190.969: "Delay in Payments Due to Disputes in Coordination of Benefits" by addition to read as follows:

Delay in Payments Due to Disputes in Coordination of Benefits, H-190.969
Our AMA:
(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;
(2) includes the "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;
(3) urges state medical associations to advocate for the inclusion of the "employer first rule", and "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;
(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;
(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;
(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and
(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.

702. PROVIDING REDUCED PARKING FOR PATIENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-373.992

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 parking costs.

703. TRIBAL HEALTH PROGRAM ELECTRONIC HEALTH RECORD MODERNIZATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy H-478.975

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.

704. INTERRUPTED PATIENT SLEEP
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-373.991

RESOLVED, That our American Medical Association encourage physicians, trainees, patient 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; and be it further

RESOLVED, That our AMA support efforts to improve quality, duration, and timing of patient sleep.

705. AGING AND DEMENTIA FRIENDLY HEALTH SYSTEMS
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: POLICIES H-280.944 AND H-280.945 BE 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.

706. REVISION OF H-185.921, REMOVAL OF AMA SUPPORT FOR APPLIED BEHAVIOR ANALYSIS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policies H-185.921 and H-90.962

RESOLVED, That our American Medical Association support research toward the evaluation and the development of interventions and programs for autistic individuals; 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; and be it further

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~~.

707. EXPEDITING REPAIRS FOR POWER AND MANUAL WHEELCHAIRS

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ALTERNATE RESOLUTION 707 ADOPTED IN LIEU OF RESOLUTION 707
See Policy H-185.912

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; and be it further

RESOLVED, That our AMA identify procedures for obtaining changes to Medicare and other payers' current policies on repairing wheelchairs; 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.

Resoltuion 708 was withdrawn.

709. ACCESS TO TRIAL OF LABOR AFTER CESAREAN
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS TITLE CHANGED
See Policy H-525.972

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; 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.

710. PROTECT PATIENTS WITH MEDICAL DEBT BURDEN
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: REFERRED

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.

711. DOCTORS' RISK FOR TERMINATION OF LIABILITY COVERAGE OR MEDICAL PRIVILEGES CONSEQUENT TO DOBBS
Introduced by Missouri

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ALTERNATE RESOLUTION 711 ADOPTED IN LIEU OF RESOLUTION 711
See Policy D-5.999

RESOLVED, 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, <u>including adverse medical licensing actions and the termination of medical liability coverage,</u> 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.

712. MEDICAL BANKRUPTCY – A UNIQUE FEATURE IN THE USA
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: REFERRED

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.

713. REDESIGNING THE MEDICARE HOSPICE BENEFIT
Introduced by American Academy of Hospice and Palliative Medicine

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-330.895

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; and be it further

RESOLVED, That our AMA advocate for a reformed Medicare hospice benefit that may incorporates the following components:

1. Hospice eligibility should not be based solely on a specified prognosis or life expectancy but rather on patients' needs.
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.

714. IMPROVING HOSPICE PROGRAM INTEGRITY
Introduced by American Academy of Hospice & Palliative Medicine

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy D-85.991

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; 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; 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; 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; 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.

715. PUBLISHED METRICS FOR HOSPITALS AND HOSPITAL SYSTEMS
Introduced by American Association of Neurological Surgeons, Congress of Neurological Surgeons

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: REFERRED
WITH REPORT BACK NO LATER THAN I-24

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.

716. TRANSPARENCY AND ACCOUNTABILITY OF HOSPITALS AND HOSPITAL SYSTEMS
Introduced by American Association of Neurological Surgeons, Congress of Neurological Surgeons

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
See Policy D-200.971

RESOLVED, That our American Medical Association identify options for developing and implementing processes — including increased transparency of physician complaints made to the Equal Employment Opportunity Commission and The Joint Commission — for tracking and monitoring physician complaints against hospitals and hospitals systems and report back with recommendations for implementing such processes, including potential revisions to the Health Care Quality Improvement Act of 1986 to include monetary penalties for institutions performing bad-faith peer reviews.

717. IMPROVING PATIENT ACCESS TO SUPPLEMENTAL OXYGEN THERAPIES
Introduced by American College of Chest Physicians

Considered on reaffirmation calendar.

HOD ACTION: POLICY H-285.998 REAFFIRMED
IN LIEU OF THE FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association advocate for the adoption of a CMS-crafted, patient- and provider- endorsed, clinical template in lieu of medical record review to maintain patient access to supplemental oxygen; and be it further

RESOLVED, That our AMA, to ensure predictable reimbursement and establish medical necessity, advocate for CMS to establish a CMS-crafted, patient- and provider- endorsed, clinical template as the national standard documentation for supplemental oxygen suppliers.

718. INSURANCE COVERAGE OF FDA APPROVED MEDICATIONS AND DEVICES

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ALTERNATE RESOLUTION 718 ADOPTED IN LIEU OF RESOLUTION 718
See Policy H-100.991

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.

719. CARE PARTNER ACCESS TO MEDICAL RECORDS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-315.967

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; 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 and revocation to selected portions of their records, including easy to understand information on use of this information and a user-friendly consent mechanism; and be it further

720. PRIOR AUTHORIZATION COSTS, AMA UPDATE TO CMS

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ALTERNATE RESOLUTION 720 ADOPTED IN LIEU OF RESOLUTION 720
See Policy D-320.976

RESOLVED, That our AMA continue to conduct research on the costs associated with prior authorization by utilizing AMA and other data sources.

721. USE OF AUGMENTED INTELLIGENCE FOR PRIOR AUTHORIZATION
Introduced by American Society for Gastrointestinal Endoscopy, American Academy of Physical Medicine and Rehabilitation, American College of Gastroenterology, American Gastroenterological Association, American Society for Surgery of the Hand Professional Organization, American Society of Echocardiography, North American Spine Society, Society for Cardiovascular, Angiography & Interventions

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS TITLE CHANGED
See Policy D-480.956

RESOLVED, That our American Medical Association advocate for greater regulatory oversight of the use of 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 such reviews include human examination of patient records prior to a care denial.

722. EXPANDING PROTECTIONS OF END-OF-LIFE CARE
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: REFFERED

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.

723. VERTICAL CONSOLIDATION IN HEALTH CARE – MARKETS OR MONOPOLIES
Introduced by Texas

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ALTERNATE RESOLUTION 723 ADOPTED
IN LIEU OF RESOLUTION 723
See Policy D-160.908

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; 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; 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.

724. RURAL HOSPITAL PAYMENT MODELS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED
POLICIES H-465.979, H-200.972, H-465.990, AND H-465.994 REAFFIRMED
See Policies D-465.996, H-465.979, H-200.972, H-465.990, and H-465.994

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; 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; and be it further

RESOLVED, That our AMA reaffirms policies H-465.979, H-200.972, H-465.990, and H-465.994.

725. THE ECONOMICS OF PRIOR AUTHORIZATION
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: 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.

726. PROPER USE OF OVERSEAS VIRTUAL ASSISTANTS IN MEDICAL PRACTICE
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-200.947

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; and be further

RESOLVED, That our AMA study and offer formal guidance for physicians on how best to utilize overseas virtual assistants to ensure protections of patients, physicians, practices, and equitable employment in communities served, in a manner consistent with appropriate compliance standards.

727. HEALTH SYSTEM CONSOLIDATION
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-160.907

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; 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 an 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; and be it further

RESOLVED, That our AMA report the initial findings of this study to the House of Delegates by Annual 2024; 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.

728. DISCHARGE CONSOLIDATED CLINICAL DOCUMENT ARCHITECTURE (C-CDA) MINIMUM DATA SET CONTENT AND ORDER PRIORITY

Introduced by Texas

Reference committee hearing: see report of Reference Committee G.

HOD ACTION: POLICIES D-160.913, D-478.973, AND D-478.996 BE 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 Clinical 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.