AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION
(Annual 2025)

Report of the Medical Student Section Reference Committee

Laurie Lapp and Rusty Hawes, Co-Chairs

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 122 - Opposing Pharmacy Benefit Managers Spread Pricing
2. Resolution 601 - Removal of HCC from MSS IOPs
3. ATF Report B - MSS Policy Archives: MSS Positions, Policy Outcomes, and Other Records
4. ATF Report C - Big Wins Report: Identifying & Highlighting Notable MSS Advocacy
5. ATF Report D - State Advocacy Collaboration Report
6. ATF Report E - Membership and Engagement Report
7. GC Report B - Sunset Report
8. GC Report C - Membership Report
9. GC Report D - MSS Standing Committee Restructuring: A-25 Update

RECOMMENDED FOR ADOPTION AS AMENDED

10. Resolution 109 - Improving HCBS Waiver Waiting List Management
11. Resolution 112 - Addressing Anti-Physician Contractual Provisions
12. Resolution 215 - Federal Truth and Healing Commission on Indian Boarding Schools
13. Resolution 217 - Enhancing Protections Against Child Labor Exploitation
14. Resolution 434 - Enhancing Disaster Preparedness Mechanisms for People with Disabilities
15. Resolution 602 - Consolidation of MSS Public Health Positions
16. Resolution 603 - Regional Delegate & Alternate Delegate Election Timing
17. CME Report A - Quadrennial Review of Medical School Tuition Policies, Affordability, Debt Burden, & Impact on Specialty Choice & Applicant Diversity
18. GC Report A – Biennial Review of Organizations Seated in the AMA-MSS Assembly

RECOMMENDED FOR ADOPTION IN LIEU OF

19. Resolution 207 - Establishing Healthcare Monitoring and Accountability in ICE Detention Facilities
20. Resolution 409 - Culturally and Religiously Inclusive Food Options

21. ATF Report A - MSS Archives Task Force Report Overview
22. ATF Report F - JAMA Collaboration

RECOMMENDED FOR REFERRAL

23. Resolution 309 - Expanding the Native Hawaiian Health Scholarship Program Eligibility

RECOMMENDED FOR NOT ADOPTION

24. Resolution 005 - Protection of Surrogacy and Parental Rights
25. Resolution 014 - Support for Direct Primary Care
26. Resolution 016 - An Update: Ensuring Responsible AI Use in Healthcare
27. Resolution 024 - Support for Consistent Use of Interpreters in the Intra- and Perioperative Period
28. Resolution 108 - Revising Medicaid Policies for Permanent Contraception
29. Resolution 205 - Support for Protecting Children from Harmful Custody Proceedings
30. Resolution 208 - Removing Barriers for Asylum-Seeking Adolescents Seeking Marketplace Coverage
31. Resolution 210 - Improving Maternal Health Care Insurance Coverage for Asylum Seekers
32. Resolution 212 - Increasing Health Screening Standards in Carceral Settings
33. Resolution 216 - Addressing Post-Discharge Rehabilitation Care for the Homeless
34. Resolution 306 - Addressing Food Inequity for Medical Students
35. Resolution 307 - International Recognition of Doctors of Osteopathy
36. Resolution 308 - Including Incarcerated Patient Care in Medical Education
37. Resolution 323 - Support for the Ethical Sourcing of Anatomy Dissection Images
38. Resolution 405 - Supporting Infectious Disease Preparedness and Funding
39. Resolution 411 - Expanding Asylum Qualifications
40. Resolution 414 - Integrating Environmental Health Into Electronic Health Records
41. Resolution 420 - Updating U.S. Food and Drug Administration (FDA) Nutrition Guidelines
42. Resolution 423 - Addressing Public Health Risks of Online Sports Betting
43. Resolution 427 - Increasing Support for Global Surgery and Global Health Educational Programs
44. Resolution 429 - Increase Classroom Physical Activity
45. Resolution 432 - Mandatory Gluten Labeling in Medications, Supplements, and Herbal Remedies
46. Resolution 433 - Standardizing Safe Haven Laws: Ensuring Medical Care & Support for Surrendered Infants
47. Resolution 438 - Reducing Airborne Transmission of Pathogens

48. Resolution 440 - Addressing Housing Needs of the Native Hawaiian Diaspora
49. Resolution 505 - Promoting Procedural POCUS Use and Availability
50. Resolution 508 - Ensuring Environmental Sustainability in AI Applications
51. Resolution 509 - Removing Barriers for Open Access to Medical Research
52. CHIT Report - Emergency Preparedness in EHR Downtime and Healthcare Technology Disruptions

RECOMMENDED FOR FILING

53. GC Report E - MSSAI Report
54. SD Report A - Delegate Report: Policy Proceedings of the Interim 2024 House of Delegates Meeting

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 122 - OPPOSING PHARMACY BENEFIT MANAGERS SPREAD PRICING

RECOMMENDATION:

Resolution 122 be <u>adopted</u>.

RESOLVED, that our American Medical Association (1) oppose the use of spread pricing by Pharmacy Benefit Managers (PBMs); (2) advocate for federal and state legislation and regulation that prohibits the use of spread pricing by PBMs; and (3) support policies requiring PBMs to use transparent, pass-through pricing models that ensure fair and consistent reimbursement to pharmacies, physicians, and patients.

VRC testimony was supportive. Your Reference Committee agrees with testimony that this is a timely issue, and the resolved clause builds upon existing AMA policy by specifying the usage of particular models to increase Pharmacy Benefit Managers (PBM) transparency. We agree with testimony from members and staff that this resolution is actionable and feasible as written. Thus, your Reference Committee recommends Resolution 122 be adopted.

(2) RESOLUTION 601 - REMOVAL OF HCC FROM MSS IOPS

RECOMMENDATION:

Resolution 601 be <u>adopted</u>.

RESOLVED, that our AMA-MSS remove specific reference to the AMA HOD Coordinating Committee (HCC) at the time of the next review of the MSS internal operating procedures (IOPs).

VRC testimony was broadly supportive. Your Reference Committee agrees with testimony that this resolution codifies an important update to MSS governance that has already been put into practice. We agree with testimony to adopt the resolution as written and leave the purpose and role of IMPACT flexible by not codifying this group in the MSS IOPs. Your Reference Committee recommends Resolution 601 be adopted.

(3) ATF REPORT B - MSS POLICY ARCHIVES: MSS POSITIONS, POLICY OUTCOMES, AND OTHER RECORDS

RECOMMENDATION:

ATF Report B be adopted.

RESOLVED that our AMA-MSS:
(1) maintain a MSS Positions Compendium containing (1) all current MSS positions along with a timeline of their adoption, amendments, and reaffirmations and outcomes of resolutions that were sent to the AMA House of Delegates (and resultant policies), and (2) a separate section for rescinded MSS positions with accompanying rationale for their rescission;
(2) maintain a MSS Positions Outcomes Archive that will include at minimum authorship information, links to the original resolution, final language adopted by the MSS, final language adopted by the HOD, links to the HOD Policy Finder, implementation notes regarding AMA actions, and other links to media coverage, actions taken by the AMA and other parties resulting from the resolution;
(3) identify MSS big policy wins after each annual and interim meeting as relevant at other timepoints;
(4) provide information to the MSS regarding how to find and track outcomes of resolutions forwarded to HOD and implementation of associated adopted AMA policy;
(5) collaborate with appropriate stakeholders including MSS standing committees, MSS regions, and AMA staff to create and promote MSS notable success and advocacy wins to medical students and the public;
(6) produce an annotated reference committee report indicating the final MSS assembly outcome at each meeting;
(7) produce and maintain confidential archives of notes on information gathered regarding other delegations stances on MSS items and actions taken by the MSS Caucus at HOD.

VRC testimony was supportive. Your Reference Committee thanks the Archives Task Force for a report that outlines feasible and actionable next steps to improve MSS positions tracking and outcomes archiving. Your Reference Committee recommends ATF Report B be adopted.

(4) ATF REPORT C - BIG WINS REPORT: IDENTIFYING & HIGHLIGHTING NOTABLE MSS ADVOCACY

RECOMMENDATION:

ATF Report C be adopted.

Your Archives Task Force recommends members view the “ATF Report B: MSS Policy Archives: MSS Positions, Policy Outcomes, and Other Records” for recommendations related to this report and the remainder of this report be filed.

VRC testimony was supportive. Your Reference Committee thanks the Archives Task Force for their time and agrees with testimony that the report does a great job of

compiling relevant information on AMA-MSS advocacy wins. Your Reference Committee recommends ATF Report C be adopted.

(5) ATF REPORT D - STATE ADVOCACY COLLABORATION REPORT

RECOMMENDATION:

ATF Report D be <u>adopted</u>.

Your Archives Task Force recommends the MSS adopt the following recommendations and the remainder of this report be filed:
RESOLVED, that our AMA MSS prioritize collaboration with state medical society leaders through:
1. Maintaining up to date contact information regarding student involvement at state medical societies/associations and contact information for student leadership;
2. Host an annual State Leadership Summit for the student leaders of state medical societies to facilitate collaboration and the exchange of ideas;
3. Collect, compile, and provide resources and information to support state leaders advocacy and engagement within the AMA MSS and with their own sections initiatives and policy processes; and be it further

RESOLVED, that the AMA MSS provide support for connecting students from different cities for travel related to away rotations, auditions, and residency interviews.

VRC testimony was supportive. Your Reference Committee thanks the Archives Task Force for their time and agrees with testimony that the report does a great job of providing feasible and sustainable recommendations for state advocacy collaboration. Your Reference Committee recommends ATF Report D be adopted.

(6) ATF REPORT E - MEMBERSHIP AND ENGAGEMENT REPORT

RECOMMENDATION:

ATF Report E be <u>adopted</u>.

Your Archives Task Force recommends the MSS adopt the following recommendations to be adopted as three separate MSS Positions and the remainder of this report be filed:

<u>Title</u>: Resources for Representation of Organized Medicine on Residency Applications and CVs
RESOLVED, that our AMA-MSS provide resources on how to cite resolutions and represent organized medicine involvement on CVs and residency application materials; and be it further

<u>Title</u>: AMA-MSS Leadership and Mentorship Tracking

RESOLVED, That our AMA-MSS empower MSS membership recruitment and retention efforts by strengthening connections among MSS members, alumni, and other physician leaders through:

(a) maintaining a current membership archive accessible to the MSS Staff, Governing Council, and Regional Executive Councils that tracks local campus section leadership who consent to sharing their contact information;
(b) maintaining a database of MSS alumni and other AMA leaders who consent to share their information to serve as resources for the MSS; and be it further

RESOLVED, At the next scheduled revision of the MSS Internal Operating Procedures (IOPs), the AMA-MSS amend IOP 4.4.4 by addition and deletion as follows:

4.4.4 **At-Large Officer.** The At-Large Officer shall:

4.4.4.1 Perform such functions as determined by the Governing Council, and assist the other officers in the performance of their duties.

4.4.4.2 Coordinate the activities of the MSS Regions, including the organization of r~~R~~egional conferences.

4.4.4.3 Maintain up to date contact information for local, state, and regional Medical Student Section leaders.

Title: MSS Awards Highlights & Archives
RESOLVED, that our AMA-MSS highlight and archive student achievements including MSS awards.

VRC testimony was supportive. Your Reference Committee thanks the Archives Task Force for their time and agrees with testimony that the report does a great job of recommending actionable outcomes that we foresee our MSS being able to implement to increase MSS membership and engagement. Your Reference Committee recommends ATF Report E be adopted.

(7) GC REPORT B – SUNSET REPORT

RECOMMENDATION:

GC Report B be adopted.

RESOLVED, that our AMA-MSS remove specific reference to the AMA HOD Coordinating Committee (HCC) at the time of the next review of the MSS internal operating procedures (IOPs).

Your AMA-MSS Governing Council recommends that MSS 630.044 Position titled ***Review and Revision of the MSS Positions Compendium via the Sunset and Consolidation Mechanisms*** be amended by addition and deletion as follows:

AMA-MSS will establish and use a sunset review mechanism for AMA-MSS positions with a ten-year time horizon whereby ~~a~~ MSS positions that have not been actively rescinded by the MSS Assembly ~~will remain viable for~~ are reviewed every ten years to determine if they maintain relevance and considered for sunset, consolidation, retention, or retention with amendments. The implementation of a sunset mechanism for AMA-MSS policy shall follow the following procedures:

(1) review of positions will be the ultimate responsibility of the Governing Council, whereby the report is authored by the Chair of the Governing Council with initial position recommendations being solicited from relevant Standing Committees as appropriate;
(2) The Governing Council will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset;
(3) position recommendations will be reported to the AMA-MSS Assembly at each Annual Meeting on the ten or nine and one-half year anniversary of a position's adoption, with a brief rationale accompanying each recommendation;
(4) to gradually transition to the new timeline for sunset review, the 2025-2029 Sunset Reports only review positions last reaffirmed at the Annual Meeting five years prior (not the Interim Meeting 4.5 years prior), and then the 2030 Sunset Report will begin the new 10- and 9.5-year timeline, at which point this subclause will be automatically rescinded;
(5) a consent calendar format will be used by the Assembly in considering the positions encompassed within the report;
~~(6) a vote will not be necessary on positions recommended for rescission as they will automatically expire under the auspices of the sunset mechanism unless referred back to the Governing Council;~~
(7) the MSS Governing Council should recommend positions for consolidations of groups of related positions, whereby the report(s) are authored by the MSS Chair with recommendations solicited from relevant Standing Committees as appropriate;
(8) when MSS positions are reviewed via either the sunset or consolidation mechanisms, the result of any positions submitted to HOD and associated implementation actions will be reviewed and documented for archival purposes if not already characterized;
(9) in their report on the previous HOD's proceedings, the Section Delegates will recommend changes to any MSS positions that amend AMA Policy and were considered by HOD, in order to summarize the amendment's ask and simplify the language; and
(10) any MSS positions written as "MSS will ask the AMA" will be automatically converted to past tense ("asked the AMA") after consideration by HOD as either a resolution or an amendment; and

(11) any MSS position (or portion of a position) requesting an AMA or MSS study will automatically sunset after the study is completed by either the AMA or MSS or after consideration of the study request by HOD.

Your AMA-MSS Governing Council recommends that the remainder of GC Report B be filed.

VRC testimony was supportive. Your Reference Committee agrees with testimony that this is an important positions update to address previous oversights in the sunsetting process. Thus, your Reference Committee recommends GC Report B be adopted.

(8) GC REPORT C - MEMBERSHIP REPORT

RECOMMENDATION:

GC Report C be <u>adopted</u>.

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

<u>Annual Membership Review Report</u>

1. RESOLVED, That our AMA-MSS track and store historical MSS Annual and Interim credentialing reports including quorum counts; and be it further
2. RESOLVED, That our AMA-MSS track and store historical MSS Annual and Interim registration reports; and be it further

<u>MSS Demographics Update</u>

3. RESOLVED, That our AMA-MSS amend 665.014MSS “Region Restructure Assessment During IOP Revision Process” by addition and deletion as follows:

2) in preparation for or at the time of review for possible revisions of the MSS IOPs a comprehensive report will be prepared for the MSS Assembly, to explore current barriers to medical student participation in the AMA including but not limited to cost and value of membership and conference attendance<u>,</u> ~~and~~ consider potential changes to the Region structure and function (i.e. state and school delegate allocation allocated in each Region) to be included in those revisions<u>, and report updated demographics data and actions to address any disparities found</u>; and be it further;

<u>Quadrennial Barriers to Engagement Review</u>

4. RESOLVED, That our AMA-MSS track and document registration and attendance at POTFS, MAC, and AIAW to be included in the quadrennial review report; and be it further
5. RESOLVED, That our AMA-MSS support cost-reducing mechanisms to make all AMA Meetings accessible to attend; and be it further

6. RESOLVED, That our AMA-MSS maintain the current region structure and reevaluate at the next quadrennial report; and be it further

MSS Study of Assembly Representation

7. RESOLVED, That our AMA-MSS seek alignment between MSS definitions of "central campus" / "satellite campus" and existing definitions of these terms used for other AMA purposes; and be it further
8. RESOLVED, That our AMA-MSS amend 645.038MSS "MSS Study of Assembly Representation" by addition to read as follows:

AMA-MSS study and report back at A-26 possible approaches to amend AMA Bylaws regarding delegate representation in the MSS Assembly to:

a. change the definition of satellite campuses to address disproportionate overrepresentation of some medical schools; and
b. adjust the threshold at which a medical school is granted more than 1 voting delegate and 1 alternate delegate.

VRC testimony was supportive. Your Reference Committee thanks the MSS Governing Council for a comprehensive report on membership. We believe this report helps to provide an overarching collection of helpful data on membership of the MSS Assembly for tracking and engagement metrics. Your Reference Committee recommends GC Report C be adopted.

(9) GC REPORT D - MSS STANDING COMMITTEE RESTRUCTURING: A-25 UPDATE

RECOMMENDATION:

GC Report D be adopted.

Your MSS Governing Council recommends that MSS Position 640.015MSS "Standing Committee Task Force Report" be amended by addition and deletion as below and the remainder of this report be filed:

"AMA-MSS (1) Governing Council (a) implement the recommendations adopted by the MSS Assembly from the Standing Committee Task Force to restructure the Standing Committee framework and leadership model, (b) clarify Standing Committee responsibilities and objectives, and (c) enhance operational efficiency;
(2) AMA-MSS Governing Council (a) restructure the existing Standing Committees into the delineated structure below with flexibility for Standing Committees to create additional subcommittees as appropriate and (b) include a timeline and requirements for leadership selection;

a) Committee on Health Economics & Coverage (CHEC)
b) Committee on Humanism & Ethics in Medicine (CHEIM)

c) Committee on Civil Rights (CCR)
d) Committee on Public Health (CPH)
e) Committee on Science & Technology (CST)
f) Committee on Medical Education (CME)
g) Committee on Gender & Sexual Health (CGSH)
Subcommittee on Women in Medicine
Subcommittee on LGBTQ+ Affairs
h) Committee on Health Justice (CHJ)
Subcommittee on Disability Affairs
Subcommittee on Minority Affairs
Subcommittee on Tribal Affairs

(3) AMA-MSS Governing Council restructure the Committee on Long Range Planning to serve in an advisory capacity led by the MSS GC Chair, who will appoint members to the committee based on applications demonstrating significant previous AMA experience, including, but not limited to, considering applications from former Governing Council and BOT members as well as current and former Councilors; and be it further

(4) AMA-MSS Governing Council restructure the Committee on Impact, Policy, and Action (IMPACT) to serve as a group led by the MSS Section Delegates, to assist with resolution review responsibilities as needed, document HOD results and implementation actions related to MSS resolutions for the MSS archives, participate in the sunset and consolidation processes for MSS positions, and emphasize training for new MSS members;

(5) every Standing Committee leadership team develop a detailed strategic plan at the beginning of their terms;

(6) AMA-MSS Governing Council develop a leadership and membership review and recall system and outline this system in the I-24 report;

(7) AMA-MSS retain the current committee structure for the 2024-2025 term and implement the new committee structure, including a new timeline where the Governing Council elects standing committee chairs and vice chairs prior to the Annual meeting for the 2025-2026 term.

(8) a new Standing Committee Task Force will be formed to review the functioning of the new structure and write an informational report regarding the progress of transitions at the I-2~~5~~6 meeting. They will also write a final report with any recommendations at the A-2~~6~~7 meeting;

(9) the revision and implementation of changes to Standing Committee structures and functions will be reviewed after three years at A-30 prior to the Quadrennial Internal Operating Procedures (IOPs) Review Report and following this, this review will be ~~are~~ exclusively done at four-year intervals ~~after the completion of the 2025-2026 task force with the next report due at A-30.~~

(10) the MSS standing committees execute, at minimum, the following functions under the direction of the MSS Governing Council:

a) Provide recommendations for the policies reviewed as part of the AMA-MSS sunset and consolidation mechanisms under the coordination of the MSS Chair, Vice Chair, and Section Delegates;

b) Assist in the resolution review process under the coordination of the Section Delegates and Vice Chair;

c) Host resolution onboarding twice a year led by appropriate Standing Committee leadership to ensure Standing Committee members are all adequately trained to review resolutions.

d) Author reports requested by the MSS Assembly and/or MSS Governing Council, with reports expected at the next MSS Assembly meeting
e) One report extension can be granted without question with further extensions will be granted upon approval of appropriate Governing Council members. This timeline will be shared with Assembly at the original deadline meeting;
f) Produce whereas clauses to facilitate the transfer of any adopted report and, if applicable, to MSS-sponsored resolutions submitted to the AMA House of Delegates.
g) Monitor federal legislation, regulation, and litigation relating to their subject area and work with other MSS members and the MSS Governing Council to organize student-led advocacy efforts and request actions by AMA staff as appropriate;
h) Organize educational programming and advocacy initiatives as necessary and appropriate; and be it further
i) Author comments for AMA Council reports, as directed by the MSS Section Delegates; and be it further
j) Support the MSS Governing Council and Staff in tracking and publicizing outcomes and implementation of MSS authored items at the AMA House of Delegates in the Standing Committee area of expertise; and be it further
(11) that our MSS remove specific reference to the Committee on Long Range Planning (COLRP) from the MSS IOPs during its next scheduled revision, to allow for flexibility as our Standing Committee structure continues to evolve and prevent possible incongruence between the IOPs and future MSS practice, without compelling the MSS to maintain COLRP simply because it is outlined in the IOPs."

VRC testimony was supportive. Your Reference Committee agrees that this report succinctly lays out the new MSS Standing Committee structure that has been in the making for multiple policy cycles. The concerns shared on the VRC regarding the leadership structure can be addressed as this new leadership structure continues to evolve and as next year's task force continues to work with the MSS Governing Council and Standing Committees. Your Reference Committee recommends GC Report D be adopted and the remainder of this report be filed.

RECOMMENDED FOR ADOPTION AS AMENDED

(10) RESOLUTION 109 - IMPROVING HCBS WAIVER WAITING LIST MANAGEMENT

RECOMMENDATION A:

The second Resolve of Resolution 109 be <u>amended by deletion:</u>

~~**RESOLVED, that our AMA support enforcement against unauthorized HCBS waiting list use.**~~

RECOMMENDATION B:

Resolution 109 be <u>adopted as amended</u>.

RESOLVED, that our American Medical Association support automatic eligibility screening for home or community-based services (HCBS) waivers; and be it further

RESOLVED, that our AMA support enforcement against unauthorized HCBS waiting list use.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the first resolve is novel and the AMA can continue their work to support automatic enrollments and have meaningful impact. We agree with testimony that the second resolve is reaffirmation of existing AMA policy H-280.944. Thus, the Reference Committee recommends Resolution 109 be adopted as amended.

Financing of Home and Community-Based Services H-280.944
Our American Medical Association supports federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS).
Our AMA supports policies that help train, retain, and develop an adequate HCBS workforce.
Our AMA supports efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS.
Our AMA supports that Medicaid's Money Follows the Person demonstration program be extended or made permanent.
Our AMA supports cross-agency and federal-state strategies that can help improve coordination among HCBS programs and streamline funding and the provision of services.
Our AMA supports HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices.
Our AMA supports that the Centers for Medicare and Medicaid Services and private insurers extend flexibility to implement innovative programs including but not limited to hospital at home programs. [CMS Rep. 4, I-21Reaffirmed: A-23]

(11) RESOLUTION 112 - ADDRESSING ANTI-PHYSICIAN CONTRACTUAL PROVISIONS

RECOMMENDATION A:

Resolution 112 be amended by addition and deletion:

RESOLVED, that our ~~American Medical Association~~AMA-MSS ~~study the prevalence and impact~~support policies which promote the investigation and/or invalidation of contractual provisions which require physicians to (i) pay for tail insurance or (ii) indemnify their employers~~, and return recommendations for policy relating to these practices~~.

RECOMMENDATION B:

Resolution 112 be adopted as amended.

RESOLVED, that our American Medical Association study the prevalence and impact of contractual provisions which require physicians to (i) pay for tail insurance or (ii) indemnify their employers, and return recommendations for policy relating to these practices.

VRC testimony was supportive. Your Reference Committee agrees with testimony from the authors to amend the resolve to make the policy an internal position in light of ongoing collaborations with the AMA Organized Medical Staff Section. Thus, the Reference Committee recommends Resolution 112 be adopted as amended.

(12) RESOLUTION 215 - FEDERAL TRUTH AND HEALING COMMISSION ON INDIAN BOARDING SCHOOLS

RECOMMENDATION A:

Resolution 215 be amended by addition and deletion:

RESOLVED, that our American Medical Association support efforts to address the historical injustices and ongoing health impacts of Indian boarding schools~~, including but not limited to governmental acknowledgment, documentation of human rights violations, cultural and language revitalization programs, and health-focused reparative measures for Tribal Nations~~.

RECOMMENDATION B:

Resolution 215 be adopted as amended.

RESOLVED, that our American Medical Association support efforts to address the historical injustices and ongoing health impacts of Indian boarding schools, including but not limited to governmental acknowledgment, documentation of human rights violations, cultural and language revitalization programs, and health-focused reparative measures for Tribal Nations.

VRC testimony was broadly supportive. Your Reference Committee agrees with testimony that the resolution is not reaffirmation of H-350.976 because this resolution expands on current policy to include historical trauma, truth, and healing initiatives. We agree with testimony to amend the resolution to broaden the language and in turn broaden the scope of advocacy on this issue. Your Reference Committee recommends Resolution 215 be adopted as amended.

(13) RESOLUTION 217 - ENHANCING PROTECTIONS AGAINST CHILD LABOR EXPLOITATION

RECOMMENDATION A:

Resolution 217 be amended by addition and deletion of the first Resolve:

RESOLVED, that our American Medical Association supports ~~legislative and regulatory~~ efforts to strengthen federal and state child labor protections and their enforcement, including~~such as~~ increasing employer penalties, ~~expanding relevant oversight and funding,~~ maintaining minimum working ages, maintaining maximum allowable work hours, and prohibiting work in~~and revising~~ hazardous occupations~~ and their exemptions~~; and be it further

RECOMMENDATION B:

Resolution 217 be amended by deletion of the second Resolve:

~~**RESOLVED, that our AMA oppose any efforts to weaken enforcement mechanisms or erode protections for working children, such as lowering minimum working ages, increasing allowable work hours for minors under 16, and permitting minors under 18 to work in hazardous occupations.**~~

RECOMMENDATION C:

Resolution 217 be adopted as amended.

RESOLVED, that our American Medical Association support legislative and regulatory efforts to strengthen federal and state child labor protections and enforcement, such as

increasing penalties, expanding relevant oversight and funding, and revising hazardous occupations and their exemptions; and be it further

RESOLVED, that our AMA oppose any efforts to weaken enforcement mechanisms or erode protections for working children, such as lowering minimum working ages, increasing allowable work hours for minors under 16, and permitting minors under 18 to work in hazardous occupations.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the resolution is not reaffirmation of H-60.962 because this resolution calls for legislative action. We agree with testimony to amend the resolution by combining the resolve clauses to streamline the ask without sacrificing the content. Thus, the Reference Committee recommends Resolution 217 be adopted as amended.

(14) RESOLUTION 434 - ENHANCING DISASTER PREPAREDNESS MECHANISMS FOR PEOPLE WITH DISABILITIES

RECOMMENDATION A:

The first Resolve of Resolution 434 be <u>amended by deletion:</u>

~~**RESOLVED, that our American Medical Association support federal and state policies requiring periodic ADA compliance audits of emergency preparedness plans to ensure accessible evacuation routes, shelters, and communication methods for people with disabilities; and be it further**~~

RECOMMENDATION B:

The third Resolve of Resolution 434 be <u>amended by addition:</u>

RESOLVED, that our AMA support increased federal and state funding for disability-specific disaster preparedness measures such as assistive technologies, durable medical equipment, mobility devices, and education programs <u>for individuals with disabilities</u> in collaboration with relevant stakeholders.

RECOMMENDATION C:

Resolution 434 be <u>adopted as amended</u>.

RESOLVED, that our American Medical Association support federal and state policies requiring periodic ADA compliance audits of emergency preparedness plans to ensure accessible evacuation routes, shelters, and communication methods for people with disabilities; and be it further

RESOLVED, that our AMA, in coordination with relevant stakeholders, advocate for greater integration of inclusive emergency alert systems (e.g., visual, auditory, and haptic notifications) in emergency preparedness planning to ensure disaster response accessibility for people with disabilities; and be it further

RESOLVED, that our AMA support increased federal and state funding for disability-specific disaster preparedness measures such as assistive technologies, durable medical equipment, mobility devices, and education programs in collaboration with relevant stakeholders.

VRC testimony was supportive. Your Reference Committee agrees with testimony that the first resolve is outside of the AMA's scope because The Americans with Disabilities Act (ADA) is enforced at the federal level and compliance audits are done at the state level. We also agree with testimony to amend the third resolve to clarify the asks of this resolution to focus on individuals with disabilities. Thus, the Reference Committee recommends Resolution 434 be adopted as amended.

(15) RESOLUTION 602 - CONSOLIDATION OF MSS PUBLIC HEALTH POSITIONS

RECOMMENDATION A:

Resolution 602 be amended by addition and deletion of the first Resolve:

RESOLVED, that our AMA-MSS amend 440.048MSS "Eradicating Homelessness" by addition and deletion as follows:

440.048MSS ~~Eradicating Homelessness~~ AMA-MSS Support for the Homeless Population: AMA-MSS asked the AMA to: (1) support improving the health outcomes and decreasing the health care costs of treating the chronically homeless through housing first approaches; ~~and~~ (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness; (3) to support the development of regulations and incentives to encourage retention of homeless patients in HIV/AIDS treatment programs; (4) to recognize that stable housing promotes adherence to HIV treatment; (5) support access to stable housing; (6) to recognize and support the use of Street Medicine programs , and reimbursement by Medicaid and other public insurance for their maintenance (7) support 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; (8) include working with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance; (9) oppose measures that

criminalize necessary means of living among homeless persons, including, but not limited to, sitting or sleeping in public spaces; (10) advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights; (11) recognize that among the homeless population, a lack of identification card serves as a barrier to accessing medical care as well as fundamental services that support healthy lifestyle; (12) support legislation and policy changes that aim to provide a streamlined and simplified application process for obtaining identification cards that facilitate accessibility to the homeless population; and (13) promote legislation changes and policy initiatives focused on providing identification cards to homeless individuals without charge

RECOMMENDATION B:

Resolution 602 be adopted as amended.

RESOLVED, that our AMA-MSS amend 440.048MSS "Eradicating Homelessness" by addition and deletion as follows:

440.048MSS Eradicating Homelessness: AMA-MSS asked the AMA to: (1) support improving the health outcomes and decreasing the health care costs of treating the chronically homeless through housing first approaches; ~~and~~ (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness; (3) to support the development of regulations and incentives to encourage retention of homeless patients in HIV/AIDS treatment programs; (4) to recognize that stable housing promotes adherence to HIV treatment; (5) support access to stable housing; (6) to recognize and support the use of Street Medicine programs , and reimbursement by Medicaid and other public insurance for their maintenance (7) support 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; (8) include working with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance; (9) oppose measures that criminalize necessary means of living among homeless persons, including, but not limited to, sitting or sleeping in public spaces; (10) advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights; (11) recognize that among the homeless population, a lack of identification card serves as a barrier to accessing medical care as well as fundamental services that support healthy lifestyle; (12) support legislation and policy changes that aim to provide a streamlined and simplified application process for obtaining identification cards that facilitate accessibility to the homeless population; and (13) promote legislation changes and policy initiatives focused on providing identification cards to homeless individuals without charge

and be it further

RESOLVED, that our AMA-MSS rescind 20.024MSS, 160.043MSS, 440.060MSS, 440.066MSS, 440.069MSS , having been effectively consolidated into 440.048MSS; and be it further

RESOLVED, that our AMA-MSS rescind 440.079MSS, given that the study has been considered by the HOD at the Annual 2018 Meeting; and be it further

RESOLVED, that our AMA-MSS amend 245.002MSS "AMA Support for Breastfeeding" by addition and deletion as follow:

245.022MSS AMA Support for Breastfeeding: AMA-MSS ~~will~~ asked the AMA to (1) encourage perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include: (a) education of parents about the medical benefits of breastfeeding and encouragement of its practice, and (b) education of parents about formula and bottle-feeding options (2) strengthen the support for breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (3) encourage hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services (4) support legislation encouraging and promoting breastfeeding, such as tax credits for businesses that provide facilities and equipment for employed breastfeeding mothers to breastfeed or express milk on business premises and (5) support the right to breastfeed and/or pump and store breast milk for incarcerated mothers.

; and be it further

RESOLVED, that our AMA-MSS rescind 245.013MSS, 270.017MSS, and 420.016MSS, having been effectively consolidated into 245.002MSS.

VRC testimony was supportive. Your Reference Committee agrees with testimony that the resolution consolidates MSS positions to streamline our MSS Positions Compendium on two public health topics. We agree with testimony to update the title of the consolidated position "Eradicating Homelessness" to "AMA-MSS Support for the Homeless Population" to capture the position's content more accurately. Thus, the Reference Committee recommends Resolution 602 be adopted as amended.

(16) RESOLUTION 603 - REGIONAL DELEGATE & ALTERNATE DELEGATE ELECTION TIMING

RECOMMENDATION A:

Resolution 603 be amended by addition and deletion:

RESOLVED, that our ~~American Medical Association~~AMA-MSS amend the AMA Constitution and Bylaws Clause 2.3.3 by addition and deletion as follows:

2.3.3 Election. Medical student regional delegates and alternates shall be elected by the Medical Student Section in accordance with procedures adopted by the Section. Each elected delegate and alternate delegate must receive written endorsement from their constituent association in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. Delegates and alternate delegates shall be elected within 10 days of the closure of ~~at the Business Meeting of the Medical Student Section prior to~~ the Interim Meeting of the House of Delegates. Delegates and alternate delegates shall be seated at the next Annual Meeting of the House of Delegates.

RECOMMENDATION B:

Resolution 603 be adopted as amended.

RESOLVED, that our American Medical Association amend the AMA Constitution and Bylaws Clause 2.3.3 by addition and deletion as follows:

2.3.3 Election. Medical student regional delegates and alternates shall be elected by the Medical Student Section in accordance with procedures adopted by the Section. Each elected delegate and alternate delegate must receive written endorsement from their constituent association in accordance with procedures adopted by the Medical Student Section and approved by the Board of Trustees. Delegates and alternate delegates shall be elected within 10 days of the closure of ~~at the Business Meeting of the Medical Student Section prior to~~ the Interim Meeting of the House of Delegates. Delegates and alternate delegates shall be seated at the next Annual Meeting of the House of Delegates.

VRC testimony was supportive. Your Reference Committee agrees with testimony that it is important to codify this election timing that has already been put into practice by MSS. We believe that adding this as an internal position will allow the MSS to forward this to the AMA HOD at the appropriate time. Thus, the Reference Committee recommends Resolution 603 be adopted as amended.

(17) GC REPORT A - BIENNIAL REVIEW OF ORGANIZATIONS SEATED IN THE AMA-MSS ASSEMBLY

RECOMMENDATION A:

GC Report A be amended by addition of a new Resolve:

RESOLVED, that our AMA-MSS study best practices for representation and involvement including:
(a) outlining responsibilities and engagement opportunities throughout the year and at the MSS meeting; and
(b) tracking and reporting representation and engagement within the MSS; and
(c) evaluating the criteria and review process for maintaining representation within the MSS; and
(d) defining the role of the MSS in convening these entities and fostering collaboration.

RECOMMENDATION B:

GC Report A be adopted as amended.

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

1. That our AMA-MSS retains the following National Medical Specialty Societies (NMSSs) as eligible for AMA-MSS Assembly representation:
    a. American Academy of Family Physicians (AAFP)
    b. American Academy of Pediatrics (AAP)
    c. American Academy of Ophthalmology (AAO)
    d. American College of Preventive Medicine (ACPM)
    e. American College of Surgeon (ACS)
    f. American Academy of Orthopaedic Surgeons (AAOS)
    g. American Society of Plastic Surgeons (ASPS)
    h. American Academy of Child & Adolescent Psychiatry (AACAP)
    i. American College of Emergency Physicians (ACEP)
    j. American College of Physicians (ACP)
    k. American Society of Anesthesiologists (ASA)
    l. Psychiatry Student Interest Group Network (PsychSIGN)
    m. American College of Medical Quality (ACMQ)

2. That our AMA-MSS retains the following Professional Interest Medical Association (PIMA) as eligible for AMA-MSS Assembly representation:
    a. Aerospace Medical Association (AsMA)
    b. American Association of Physicians of Indian Origin (AAPI)
    c. Health Professionals Advancing LGBTQ Equality (GLMA)
    d. American Medical Women's Association (AMWA)
    e. American Society of Military Surgeons of the US (AMSUS)

3. That our AMA-MSS retain the following Federal Services as eligible for AMA-MSS Assembly representation:
    a. United States Air Force
    b. United States Army
    c. United States Navy

4. That our AMA-MSS retains the following NMSOs as eligible for AMA-MSS Assembly representation with full voting rights:
    a. American Medical Student Association (AMSA)
    b. American Physician Scientists Association (APSA)
    c. Asian Pacific American Medical Student Association (APAMSA)
    d. Latino Medical Student Association (LMSA)
    e. Student National Medical Association (SNMA)
    f. Association of Native American Medical Students (ANAMS)
    g. Medical Student Pride Alliance (MSPA)
    h. Student Osteopathic Medical Association (SOMA).

5. That our AMA-MSS maintain the following NMSOs on probationary status for AMA-MSS Assembly Representation:
    a. National First-Generation and Low-Income in Medicine Association (FGLIMed),
    b. Medical Students with Disability and Chronic Illness (MSDCI)
    c. South Asian Medical Student Association (SAMSA)

6. That our AMA-MSS maintain the following organizations as Official Observers on of the AMA-MSS Assembly Representation:
    a. European Medical Student Association (EMSA)
    b. Medical Students for a Sustainable Future (MS4SF)
    c. Medical Students for Choice (MSFC)
    d. Student Academy of the American Academy of Physician Assistants (AAPA)
    e. Students for a National Health Program (SNaHP).

RESOLVED, that our AMA-MSS rescind MSS Positions 645.016MSS and 645.019MSS.

VRC testimony was supportive. Your Reference Committee agrees with testimony to amend the report by addition of a new resolve to ask the MSS to study the historic relationship between AMA-MSS and the above listed organizations to ensure the best way to engage and interact with the organizations seated in our AMA-MSS assembly. Thus, the Reference Committee recommends GC Report A be adopted as amended.

(18) CME REPORT A - QUADRENNIAL REVIEW OF MEDICAL SCHOOL TUITION POLICIES, AFFORDABILITY, DEBT BURDEN, & IMPACT ON SPECIALTY CHOICE & APPLICANT DIVERSITY

RECOMMENDATION A:

The first Resolve of CME Report A be <u>amended by deletion:</u>

~~**RESOLVED, that our AMA Board of Trustees and Change MedEd coalition publicize the issue of tuition transparency; and be it further**~~

RECOMMENDATION B:

The second Resolve of CME Report A be amended by addition and deletion:

RESOLVED, that our AMA work with Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other relevant stakeholders to ~~ask~~ encourage medical schools to ~~publicly distribute~~ publish student-accessible tuition spending breakdowns; and be it further

RECOMMENDATION C:

The third Resolve of CME Report A be amended by addition and deletion:

RESOLVED, that our AMA-MSS amend Policy 295.232MSS, "Understanding Philanthropic Efforts to Address Rise of Medical School Tuition" by addition and deletion to read as follows;

> **Understanding ~~Philanthropic Efforts to Address Rise of Medical School Tuition~~ the Current State of Medical School Tuition**
>
> **AMA-MSS will study this topic every four years to gain a better understanding of the challenges facing current and future medical students, including but not limited to the sustainability and impact of free and reduced medical tuition programs including, ~~but not limited to,~~ debt burden beyond medical school, effects of debt on medical specialty choice, ~~as well as~~ applicant diversity related to potential debt, and tuition transparency ~~and release its findings in an informational~~ and will report back to the Assembly at A-29 ~~A-25~~.**

RECOMMENDATION D:

CME Report A be adopted as amended.

RESOLVED, that our AMA Board of Trustees and Change MedEd coalition publicize the issue of tuition transparency; and be it further

RESOLVED, that our AMA work with Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other relevant stakeholders to ask medical schools to publicly distribute student-accessible tuition spending breakdowns; and be it further

RESOLVED, that our AMA-MSS amend Policy 295.232MSS, "Understanding Philanthropic Efforts to Address Rise of Medical School Tuition" by addition and deletion to read as follows;

> Understanding ~~Philanthropic Efforts to Address Rise of Medical School Tuition~~ the Current State of Medical School Tuition
>
> AMA-MSS will study this topic every four years to gain a better understanding of the challenges facing current and future medical students, including but not limited to the sustainability and impact of free and reduced medical tuition programs including, ~~but not limited to,~~ debt burden beyond medical school, effects of debt on medical specialty choice, ~~as well as~~ applicant diversity related to potential debt, and tuition transparency and release its findings in an informational report to the Assembly at A-29 ~~A-25~~.

VRC testimony was mixed. Your Reference Committee thanks the MSS Committee on Medical Education for their work on this report. Given that this report has been pending since the adoption of the MSS resolution that inspired this report 7 years ago, CME Report A is inherently timely and important. Your Reference Committee agrees with testimony to strike the first resolve because the ask is too specific. We agree with the amendments proposed for resolves two and three which help to streamline the verbiage and strengthen the asks. Thus, the Reference Committee recommends CME Report A be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(19) RESOLUTION 207 - ESTABLISHING HEALTHCARE MONITORING AND ACCOUNTABILITY IN ICE DETENTION FACILITIES

RECOMMENDATION:

Substitute Resolution 207 be <u>adopted in lieu of</u> Resolution 207:

<u>RESOLVED, that our AMA-MSS study the updated prevalence of waiver elimination that allows detention facilities to bypass National Detention Standards and oppose the ability of detention facilities to self-assess.</u>

RESOLVED, that our American Medical Association support the development and implementation of robust, independent, and transparent health monitoring systems in ICE detention facilities, including frequent unannounced evaluations, granular and publicly reported health metrics (e.g., access to care, mental health outcomes, chronic disease management), and follow-up inspections to ensure sustained compliance and accountability; and be it further

RESOLVED, that our AMA support the elimination of waivers that allow detention facilities to bypass National Detention Standards, and oppose the ability of detention facilities to self-assess; and be it further

RESOLVED, that our AMA support the improvement of funding structures and targeted resource allocation in ICE detention facilities that incentivize quality care delivery and continuous improvement, while identifying appropriate legislative and regulatory levers to advance healthcare transparency, oversight, and humane treatment in alignment with existing AMA policy.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the first and third resolves are covered under existing AMA policies D-350.983, H-60.906, H-350.955, H-60.986, and D-430.997. We agree with testimony that the second resolve lacks recent evidence and would benefit from an updated literature review to dig into the prevalence of waiver usage. We believe the substitute resolution calling for a study is the best opportunity for strong policy recommendations to be proffered. Thus, your Reference Committee recommends Substitute Resolution 207 be adopted in lieu of Resolution 207.

Improving Medical Care in Immigrant Detention Centers D-350.983
Our AMA will: (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional

Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention. [Res. 017, A-17]

Opposing the Detention of Migrant Children H-60.906

Our American Medical Association opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children "without unnecessary delay" when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the "least restrictive setting" possible, such as emergency foster care.

Our AMA supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children.

Our AMA urges continuity of care for migrant children released from detention facilities. [Res. 004, I-18; Reaffirmed: Res. 234, A-22]

Care of Women and Children in Family Immigration Detention H-350.955

1. Our American Medical Association recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.
5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies. [Res. 002, A-17; Appended: Res. 218, A-21; Reaffirmed: Res. 234, A-22]

Health Status of Detained and Incarcerated Youth H-60.986

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in a]dult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system. [CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16]

Support for Health Care Services to Incarcerated Persons D-430.997

1. Our American Medical Association will express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities.
2. Our AMA will encourage all correctional systems to support NCCHC accreditation.
3. Our AMA will encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding.
4. Our AMA will continue support for the programs and goals of the NCCHC through continued support for the travel expenses of our AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities.
5. Our AMA will work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort.
6. Our AMA will support an incarcerated person’s right to:

a. accessible, comprehensive, evidence-based contraception education.
b. access to reversible contraceptive methods.
c. autonomy over the decision-making process without coercion.

[Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11;

Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19; Reaffirmed: CSAPH Rep. 06, A-23; Reaffirmed: CSAPH Rep. 07, A-24; Reaffirmed: BOT Rep. 05, I-24]

(20) RESOLUTION 409 - CULTURALLY AND RELIGIOUSLY INCLUSIVE FOOD OPTIONS

RECOMMENDATION:

Substitute Resolution 409 be <u>adopted in lieu of</u> Resolution 409:

<u>RESOLVED, our AMA-MSS supports access to culturally and religiously inclusive food options in health care facilities.</u>

RESOLVED, that our AMA-MSS support our American Medical Association amending Policy H-150.949 “Healthful Food Options in Health Care Facilities” by addition to read as follows:
Healthful <u>Culturally and Religiously Sensitive</u> Food Options in Health Care Facilities H-150.949

1. Our American Medical Association encourages healthful<u>, culturally and religiously inclusive</u> food options be available, at reasonable prices and easily accessible, on the premises of health care facilities.
2. Our AMA hereby calls on all health care facilities to improve the health of patients, staff, and visitors by:
    a. Providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans fat, sodium, and added sugars.
    b. Eliminating processed meats from menus.
    c. Providing and promoting healthy beverages.
    d. <u>Improving access to culturally and religiously sensitive food options.</u>
3. Our AMA hereby calls for health care facility cafeterias and inpatient meal menus to publish nutrition information.
4. Our AMA will work with relevant stakeholders to define “access to food” for medical trainees to include overnight access to fresh<u>, culturally and religiously sensitive</u> food and healthy meal options within all training hospitals.

VRC testimony was supportive. Your Reference Committee agrees with testimony that the resolution should be kept as an internal position to support Resolution 416 coming forth from the Minority Affairs Section at the 2025 Annual Meeting of the AMA House of Delegates. We agree with testimony to adopt substitute language in lieu of the original resolve to improve positions tracking in the MSS Positions Compendium, and make language more expansive. Thus, your Reference Committee recommends Substitute Resolution 409 be adopted in lieu of Resolution 409.

(21) ATF REPORT A - MSS ARCHIVES TASK FORCE REPORT OVERVIEW

RECOMMENDATION:

Substitute ATF Report A be adopted in lieu of ATF Report A:

RESOLVED that our AMA MSS:
(1) maintain an Archiving Team to oversee prospective archiving efforts, the completion of the historical policy archives, and refinement of best practices for communication of outcomes.
(2) Review and formally define the roles and responsibilities of archiving entities as part of the A-26 Resolution Task Force Report.

Your Archives Task Force recommends that:
1) AMA-MSS Position 630.078MSS "MSS Archives Task Force" be rescinded, as it will be superseded by the recommendations in ATF Reports B-F; and
2) The remainder of this report be filed.

VRC testimony was supportive. Your Reference Committee agrees with testimony that the MSS archives would benefit from these new recommendations to continue with an archiving team and formally define the process by A-26. Thus, your Reference Committee recommends Substitute ATF Report A be adopted in lieu of ATF Report A.

(22) ATF REPORT F - JAMA COLLABORATION

RECOMMENDATION:

Substitute ATF Report F be adopted in lieu of ATF Report F:

RESOLVED, that our AMA-MSS foster opportunities for medical trainees within the JAMA Network including but not limited to:
a) Collaborate with JAMA leadership to explore opportunities for a medical trainee journal
b) Collaborate with JAMA leadership to explore opportunities for medical student leadership positions within JAMA network journals; and be it further

RESOLVED, that our AMA-MSS Governing Council and Staff continue collaborating with JAMA on medical student leadership opportunities with report back on these efforts at A-26.

Your Archives Task Force recommends that the MSS adopt the following recommendation and that the remainder of this report be filed.
RESOLVED, That our AMA foster opportunities for medical trainees within the JAMA Network through the following actions:

(a) Work with JAMA leadership to create a new JAMA Network Journal for Medical Trainees that will showcase AMA Research challenge and Poster Showcase abstracts, adopted MSS standing committee reports from the AMA-MSS Annual and Interim meetings, original research, and commentary pieces

(b) Work with JAMA leadership to create paid medical student editorial positions on the following current JAMA Network journals: JAMA Cardiology, JAMA Dermatology, JAMA Internal Medicine, JAMA Neurology, JAMA Oncology, JAMA Ophthalmology, JAMA Otolaryngology-Head & Neck Surgery, JAMA Pediatrics, JAMA Psychiatry, and JAMA Surgery

VRC testimony was mixed. Your Reference Committee agrees with testimony to make this resolution an internal ask to allow the MSS Governing Council and staff to work with JAMA collaboratively. We believe that the language of the substitute resolution is stronger because it provides a broader ask that can initiate collaboration with JAMA. Additionally, your Reference Committee found it important to add a resolve clause on a report back to the MSS assembly on the JAMA collaboration by A-26 to create an accountability mechanism. Thus, your Reference Committee recommends Substitute ATF Report A be adopted in lieu of ATF Report A.

RECOMMENDED FOR REFERRAL

(23) RESOLUTION 309 - EXPANDING THE NATIVE HAWAIIAN HEALTH SCHOLARSHIP PROGRAM ELIGIBILITY

RECOMMENDATION:

Resolution 309 be referred.

RESOLVED, that our American Medical Association support expanded funding and eligibility requirements for the Native Hawaiian Health Scholarship Program (NHHSP), or an equivalent program, to include the following entities:
(a) Native Hawaiian (NH) trainees and NH providers who are committed to providing primary care health services at Federally Qualified Health Centers (FQHCs), critical access hospitals, and Native health centers to NH patients in all U.S. states, as well as
(b) NH trainees and NH providers who provide specialized health care services to NHs in all U.S. states.

VRC testimony was supportive. Your Reference Committee agrees with testimony that the ask of this resolution addresses a novel gap in existing AMA policy. We share concerns with folks on the VRC who outlined unintended consequences such as potentially undermining the original intent of the Native Hawaiian Health Scholarship Program. We believe that input from relevant stakeholders including the Hawaii Delegation, Minority Affairs Section, and others would strengthen the ask. Thus, your Reference Committee recommends Resolution 309 be referred.

RECOMMENDED FOR NOT ADOPTION

(24) RESOLUTION 005 - PROTECTION OF SURROGACY AND PARENTAL RIGHTS

RECOMMENDATION:

Resolution 005 not be adopted.

RESOLVED, that our AMA-MSS support and advocate for improved access to evidence-based surrogacy; and be it further

RESOLVED, that our AMA-MSS support the provision of ethical guidelines, medical oversight, psychological support, legal counsel, insurance coverage and other resources provided by healthcare practitioners, legal firms, specialty societies, insurance agencies and other interested parties for intended parents, surrogates, and children born with the aid of surrogacy.

VRC testimony was supportive. The Reference Committee would like to note that the LGBTQ+ Section is currently working on this resolution in collaboration with relevant specialty societies to present at a future AMA House of Delegates Meeting. We believe this internal position is premature in light of the coordination between the LGBTQ+ Section and relevant specialty societies. Your Reference Committee agrees with testimony from specialty societies that this resolution would benefit from further wordsmithing to address unintended consequences and outdated terminology. Thus, your Reference Committee recommends Resolution 005 not be adopted.

(25) RESOLUTION 014 - SUPPORT FOR DIRECT PRIMARY CARE

RECOMMENDATION:

Resolution 014 not be adopted.

RESOLVED, that our American Medical Association advocate for policies that support the integration of Direct Primary Care (DPC) models, including ensuring fair access for patients, promoting physician autonomy, and encouraging regulatory environments that facilitate DPC practice viability; and be it further

RESOLVED, that our AMA support increased exposure to and education about DPC practice models in undergraduate, graduate, and continuing medical education, including through collaboration with relevant licensing bodies, educational institutions, and specialty organizations.

VRC testimony was mainly opposed to the resolution. The Reference Committee agrees with concerns that the resolution lacks sufficient evidence to support the claim that direct primary care will address the problem posed by the resolution. Additionally, we believe this resolution is covered by existing AMA policies H-385.912 and H-200.949 and would be better suited for advocacy at the state level. Thus, your Reference Committee recommends Resolution 014 not be adopted.

Direct Primary Care H-385.912

1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty. [Res. 103, A-16; Appended: Res. 246, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 102, A-19]

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation’s current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to

encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination… [CME Rep. 04, I-18; Reaffirmed: CMS Rep. 08, A-24]

(26) RESOLUTION 016 - AN UPDATE: ENSURING RESPONSIBLE AI USE IN HEALTHCARE

RECOMMENDATION:

Resolution 016 <u>not be adopted.</u>

RESOLVED, that our American Medical Association support the study and development of national guidelines to ensure that:

a) A robust framework for the evaluation of AI and AI-related tools in clinical settings is established, incorporating substantial physician input, including specialty societies, at every stage of assessment, from design and validation to clinical deployment and monitoring;

b) AI-driven patient communication platforms are mandated to meet evidence-based standards and are subject to rigorous review by physicians or physician-led professional societies prior to clinical deployment, with post-implementation auditing mechanisms to ensure continued safety and effectiveness;

c) Comprehensive bias detection and mitigation strategies are systematically integrated into the development, testing, and deployment of AI models to promote equitable care for all patient populations and to prevent the exacerbation of existing health disparities;

d) Standardized AI competency and ethics training, covering topics such as algorithmic bias detection, informed consent for AI-assisted care, data interpretation, and

communication of AI limitations, is incorporated into medical school curricula and continuing medical education programs to prepare physicians for the ethical and effective use of AI in clinical practice; and

e) Collaborative mechanisms are established among regulatory bodies, the AMA's existing AI and digital health task forces, academic institutions, professional societies, and technology developers to facilitate the periodic evaluation, refinement, and implementation of AI governance guidelines in healthcare.

and be it further;

RESOLVED, that our AMA further advocate for continued research and dialogue to monitor both the ongoing and emerging impacts of AI technologies, ensuring that all such innovations—whether newly developed or already in use—enhance patient care, uphold clinical standards, and prioritize equity, transparency, and physician-led oversight.

VRC testimony was mainly opposed to the resolution. The Reference Committee agrees with concerns that the resolution is covered under existing AMA policies H-480.931, H-480.939, H-480.940, H-295.857, H-480.935, and H-225.940. We agree with testimony that the asks of this resolution are not strongly supported by the evidence presented. Additionally, the AMA already has an AI Task Force that was established to address various aspects of the intersection of AI and health care. Thus, your Reference Committee recommends Resolution 016 not be adopted.

Assessing the Intersection Between AI and Health Care H-480.931
Augmented Intelligence Development, Deployment, and Use in Health Care… [BOT Rep. 01, I-24]

Augmented Intelligence in Health Care H-480.939
Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that… [BOT Rep. 21, A-19; Reaffirmation: A-22]

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.
To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.

2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:

a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
b. is transparent;
c. conforms to leading standards for reproducibility;
d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.

4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

[BOT Rep. 41, A-18; Reaffirmed: CMS Rep. 07, A-24]

Augmented Intelligence in Medical Education H-295.857

Our AMA encourages:

(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;

(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;

(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;

(4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;

(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;

(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;

(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;

(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;
(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and
(10) close collaboration with and oversight by practicing physicians in the development of AI applications. [CME Rep. 04, A-19]

Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935
Our American Medical Association will 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.
Our AMA will work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice.
Our AMA will encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs.
Our AMA will 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. [Res. 247, A-23]

Augmented Intelligence and Organized Medical Staff H-225.940
Our American Medical Association recognizes that organized medical staff should be an integral part at the outset of choosing, developing and implementing augmented intelligence and digital health tools in hospital care. That consideration is consistent with organized medical staff's primacy in overseeing safety of patient care, as well as assessing other negative unintended consequences such as interruption of, or overburdening, the physician in delivery of care. [Res. 024, A-24]

(27) RESOLUTION 024 - SUPPORT FOR CONSISTENT USE OF INTERPRETERS IN THE INTRA- AND PERIOPERATIVE PERIOD

RECOMMENDATION:

Resolution 024 <u>not be adopted.</u>

RESOLVED, that our American Medical Association work with relevant stakeholders to identify barriers and establish best practices for maintaining consistent availability of interpreter services in the intraoperative and perioperative period.

VRC testimony was mixed. The Reference Committee agrees with testimony that the asks of this resolution are covered under existing AMA policies H-160.924 and H-160.931. We believe this resolution is outside the AMA's scope as it identifies a hospital issue that is already covered under federal law; implementation of the resolution as written would be at the state or systems level. Thus, your Reference Committee recommends Resolution 024 not be adopted.

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

1. Our American Medical Association policy is that:

a. further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care;

b. treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive;

c. physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care;

d. patients should have access to documentation and communications in their preferred language, when feasible and in a manner that requires all payers to directly pay for such services; and

e. physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

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

3. Our AMA encourages hospital systems, clinics, residency programs, and medical schools to pursue opportunities for physicians, staff, and trainees to voluntarily receive medical interpreter training and certification should they desire.

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

5. Our AMA encourages hospital systems, clinics, residency programs, and medical schools to pursue opportunities for physicians, staff, and trainees to voluntarily receive medical interpreter training and certification should they desire.

[BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17; Appended: Res. 310, A-22; Adopted in lieu of: Res. 231, A-23; Modified: Res. 811, I-23]

Health Literacy H-160.931

1. Our American Medical Association recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment.
2. Our AMA encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting.
3. Our AMA will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information.
4. Our AMA encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills.
5. Our AMA encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills.
6. Our AMA encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies;
7. Our AMA encourages the allocation of federal and private funds for research on health literacy.
8. Our AMA recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit.
9. Our AMA recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate.
10. Our AMA encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.

[CSA Rep. 1, A-98; Appended: Res. 415, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-13; Reaffirmed: BOT Rep. 09, A-23]

(28) RESOLUTION 108 - REVISING MEDICAID POLICIES FOR PERMANENT CONTRACEPTION

RECOMMENDATION:

Resolution 108 <u>not be adopted.</u>

RESOLVED, that our American Medical Association will support permanent contraception policies, such as waiting periods and consent requirements, to be applied equitably across all insurance types; and be it further

RESOLVED, that our AMA will support the reduction, not abolishment, of the current mandatory 30-day waiting period for permanent contraception to 72 hours to allow for thoughtful decision-making while minimizing access barriers to permanent contraception and extend improved consent processes to all individuals over 18; and be it further

RESOLVED, that our AMA will support federal and state policy reforms and clinical infrastructure investments that advance equitable access to permanent contraception, including improved consent processes, integration of decision aids, on-site support services, and public tools such as policy trackers and model legislation to ensure patients receive timely, comprehensible, and autonomy-supportive care at the point of service.

VRC testimony was mainly opposed to the resolution. The Reference Committee agrees with testimony that the asks of this resolution are covered under existing AMA policies H-290.977, H-75.988, and H-75.990. We believe that the first resolved clause does not properly address the implementation of the ask and how permanent contraception policies would be “applied equitably” across insurance types; the second resolved clause does not have strong evidence to establish the restrictive 72 hour waiting period; and the third resolved clause would not change current AMA advocacy efforts. Your Reference Committee recommends alternate routes of advocacy in lieu of additional AMA policy on this topic. Thus, your Reference Committee recommends Resolution 108 not be adopted.

Medicaid Sterilization Services Without Time Constraints H-290.977
Our American Medical Association will pursue an action to amend federal Medicaid law and regulations to remove the time restrictions on informed consent, and thereby allow all patients, over the age of 21 and legally competent, to choose sterilization services. [Res. 226, A-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed: BOT Rep. 7, A-21]

Extension of Medicaid Coverage for Family Planning Services H-75.988
Our American Medical Association supports legislation that will allow states to extend Medicaid coverage for contraceptive education and services for at least two years postpartum for all eligible women. [Sub.

Res. 201, I-93; Reaffirmed: BOT Rep. 28, A-03; Modified: CMS Rep. 4, A-13; Reaffirmed: CMS Rep. 01, A-23]

Development and Approval of New Contraceptives H-75.990

1. Our American Medical Association supports efforts to increase public funding of contraception and fertility research.
2. Our AMA urges the FDA to consider the special health care needs of Americans who are not adequately served by existing contraceptive products when considering the safety, effectiveness, risk and benefits of new contraception drugs and devices.
3. Our AMA encourages contraceptive manufacturers to conduct post-marketing surveillance studies of contraceptive products to document the latter's long-term safety, effectiveness and acceptance, and to share that information with the FDA.

[BOT Rep. O, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21]

(29) RESOLUTION 205 - SUPPORT FOR PROTECTING CHILDREN FROM HARMFUL CUSTODY PROCEEDINGS

RECOMMENDATION:

Resolution 205 <u>not be adopted.</u>

RESOLVED, that our American Medical Association supports federal and state efforts to prohibit court-mandated reunification programs (therapy and/or camps) that employ coercive psychological tactics, isolate children from their preferred parent, or fail to assess claims of abuse or trauma appropriately; and be it further

RESOLVED, that our AMA opposes the use of Parental Alienation as admissible evidence in custody proceedings due to its lack of scientific validity and potential to undermine allegations of abuse.

VRC testimony was mixed. The Reference Committee agrees with testimony that the asks of this resolution are outside the AMA's scope. We agree with testimony from relevant specialty societies that this issue is better suited for alternate routes of advocacy as family courts are maintained at the state/county level. Thus, your Reference Committee recommends Resolution 205 not be adopted.

(30) RESOLUTION 208 - REMOVING BARRIERS FOR ASYLUM-SEEKING ADOLESCENTS SEEKING MARKETPLACE COVERAGE

RECOMMENDATION:

Resolution 208 <u>not be adopted.</u>

RESOLVED, that our American Medical Association support policies that eliminate the mandatory 180-day waiting period and work permit requirements for asylum-seeking adolescents, including unaccompanied minors, those in removal proceedings, and those who age out during the application process, to apply for Marketplace health insurance, allowing enrollment to begin as soon as required documentation has been submitted and verified, in order to promote timely coverage while maintaining procedural integrity; and be it further

RESOLVED, that our AMA support the development of linguistically and culturally appropriate outreach and enrollment efforts, including translated materials, interpreter services, and community-based navigation support, to ensure that asylum-seeking families and unaccompanied minors with limited English proficiency receive timely, accurate, and accessible information about their healthcare options; and be it further

RESOLVED, that our AMA support partnerships and implementation strategies, such as collaborations with healthcare providers, legal aid groups, and advocacy organizations, to address misinformation, streamline documentation, and provide targeted enrollment support for asylum-seeking adolescents, particularly unaccompanied minors without legal guardians.

VRC testimony was mixed between direct opposition and opposition as written. The Reference Committee agrees with concerns that the resolution is covered by existing AMA policies H-290.961, D-440.911, and H-165.823. We agree with the spirit of the resolution, however we also agree with testimony that this resolution does not present a meaningful change to AMA's advocacy efforts at this time. We are additionally concerned that portions of the asks of this resolution fall outside the scope of the AMA. Thus, your Reference Committee recommends Resolution 208 not be adopted.

Opposition to Medicaid Work Requirements H-290.961
Our AMA opposes work requirements as a criterion for Medicaid eligibility. [Res. 802, I-17; Reaffirmation: A-18]

Immigration Status in Medicaid and CHIP D-440.911
Our American Medical Association advocates for the removal of eligibility criteria based on immigration status from Medicaid and CHIP. [Res. 210, I-23]

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. That our American Medical Association advocates 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.
c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
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.
e. The public option is financially self-sustaining and has uniform solvency requirements.
f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
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.

d. recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.

5. Our American Medical Association supports federal and state efforts to provide subsidies for undocumented immigrants to purchase health insurance, including by extending eligibility for premium tax credits and cost-sharing reductions to purchase Affordable Care Act (ACA) plans.

[CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22; Modified: Res. 813, I-22; Reaffirmed: CMS Rep. 5, I-23; Appended: Res. 817, I-24]

(31) RESOLUTION 210 - IMPROVING MATERNAL HEALTH CARE INSURANCE COVERAGE FOR ASYLUM SEEKERS

RECOMMENDATION:

Resolution 210 <u>not be adopted.</u>

RESOLVED, that our American Medical Association support the expansion of health insurance coverage for all pregnant asylum seekers in all states; and be it further

RESOLVED, that our AMA support the development of outreach programs that connect pregnant asylum seekers with healthcare providers, social workers, and resources as early as possible in their pregnancy to reduce delays in care and improve pregnancy outcomes; and be it further

RESOLVED, that our AMA support early screening and treatment for pregnant asylum seekers; and be it further

RESOLVED, that our AMA support initiatives to provide culturally and linguistically appropriate services to pregnant asylum seekers, including access to interpreters and educational resources.

VRC testimony was mainly opposed. The Reference Committee agrees with concerns that the resolution is covered by existing AMA policies H-350.957, H-350.955, H-65.938, H-440.876, and H-185.917. We additionally agree with testimony from relevant specialty societies that this resolution is best suited for state-level advocacy because states have different coverage and eligibility for asylum seekers. Your Reference Committee recommends Resolution 210 not be adopted.

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA calls for asylum seekers to receive medically-appropriate care, including vaccinations, in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
4. Our AMA supports efforts to train physicians to conduct medical and psychiatric forensic evaluations for asylum seekers.
5. Our AMA supports medical education that addresses the challenges of life-altering events experienced by asylum seekers.
6. Our AMA urges physicians to provide medically-appropriate care for asylum seekers.
7. Our AMA encourages physicians to seek out organizations or agencies in need of physicians to provide these services.
8. Our AMA encourages provision of resources to assist people seeking asylum, including social and legal services.

[Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19; Modified: BOT Rep. 08, I-24]

Care of Women and Children in Family Immigration Detention H-350.955

1. Our American Medical Association recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.
5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies. [Res. 002, A-17; Appended: Res. 218, A-21; Reaffirmed: Res. 234, A-22]

Guiding Principles for the Healthcare of Migrants H-65.938

1. Our American Medical Association advocates for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the "Colombo Statement."
2. Our AMA recognizes that migration status is a social determinant of health.
3. Our AMA affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration.
4. Our AMA recognizes that the enhancement of migrants' health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families.
5. Our AMA recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard.
6. Our AMA recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization's 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by

a. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.

b. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.
c. Ensuring that the social determinants of migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.
d. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.
e. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems.

[Res. 016, A-24]

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our American Medical Association opposes
a. any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants;
b. any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and
c. proof of citizenship as a condition of providing health care.
2. Our AMA opposes any legislative proposals that would criminalize the provision of health care to undocumented residents.

[Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Modified: BOT Rep. 09, A-24]

Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917

1. Our American Medical Association acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.

2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:

a. Informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories),
b. Carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections.
c. Lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.

6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.
8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care.

These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.

9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.
11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.

[Joint CMS/CSAPH Rep. 1, I-21]

(32) RESOLUTION 212 - INCREASING HEALTH SCREENING STANDARDS IN CARCERAL SETTINGS

RECOMMENDATION:

Resolution 212 <u>not be adopted.</u>

RESOLVED, that our American Medical Association support efforts to increase access to routine health screenings for incarcerated individuals in county, state, or federal jails and prisons in a standardized manner consistent with the time intervals and clinical tests set forward by the National Institute of Health; and be it further

RESOLVED, that our AMA support efforts to ensure clinical encounters and diagnostic exams in county, state, or federal jails and prisons be conducted by qualified medical professionals, including nurse practitioners (NP's), physician assistants (PA's), and generalist physicians.

VRC testimony was mixed. The Reference Committee agrees with concerns that the resolution is covered by existing AMA policies H-430.986 and D-430.997. We agree with testimony that the asks of this resolution are timely, but this resolution would not meaningfully change the way the AMA currently advocates in carceral health. Thus, your Reference Committee recommends Resolution 212 not be adopted.

Health Care While Incarcerated H-430.986

1. Our American Medical Association advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports:

a. linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding;
b. the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community;
c. the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and

d. collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons:

a. 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;
b. 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; and
c. knowledge of the health disparities among individuals who are involved with the criminal justice system.

14. Our AMA will 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.
15. Our AMA advocates for readily accessible gender-affirming care to meet the distinct healthcare needs of transgender and gender diverse people in the carceral system, including but not limited to gender-affirming surgical procedures and the continuation or initiation of hormone therapy without disruption or delay.
16. Our AMA strongly supports carceral facilities and youth detention centers managed by the Bureau of Indian Affairs Division of Corrections be eligible for designation as Health Professional Shortage Areas and the assignment of U.S. Public Health Service Commissioned Corps officers to these facilities.
17. Our AMA advocates for the development, staffing, and operation of sustainable, on-site medical and behavioral health services, including evidence-based and culturally-appropriate addiction treatment, for incarcerated American Indian and Alaska Native persons.
18. Our AMA strongly supports routine audits and inspection of facilities managed by the Bureau of Indian Affairs Division of Correction, ensuring that these facilities abide by all standards and guidelines outlined by the National Commission on Correctional Health Care.

[CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22; Appended: Res. 244, A-23;

Appended: Res. 429, A-23; Reaffirmed: BOT Rep. 05, I-24; Appended: Res. 916, I-24; Appended: Res. 918, I-24]

Support for Health Care Services to Incarcerated Persons D-430.997

1. Our American Medical Association will express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities.
2. Our AMA will encourage all correctional systems to support NCCHC accreditation.
3. Our AMA will encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding.
4. Our AMA will continue support for the programs and goals of the NCCHC through continued support for the travel expenses of our AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities.
5. Our AMA will work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort.
6. Our AMA will support an incarcerated person’s right to:

a. accessible, comprehensive, evidence-based contraception education.
b. access to reversible contraceptive methods.
c. autonomy over the decision-making process without coercion.

[Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19; Reaffirmed: CSAPH Rep. 06, A-23; Reaffirmed: CSAPH Rep. 07, A-24; Reaffirmed: BOT Rep. 05, I-24]

(33) RESOLUTION 216 - REMOVING BARRIERS FOR ASYLUM-SEEKING ADOLESCENTS SEEKING MARKETPLACE COVERAGE

RECOMMENDATION:

Resolution 216 <u>not be adopted.</u>

RESOLVED, our AMA-MSS support efforts to reduce barriers to admission to inpatient rehabilitation facilities for individuals experiencing homelessness and the integration of rehabilitation services into housing support services and street medicine programs.

VRC testimony was mixed. The Reference Committee agrees with concerns that the resolution is covered by existing AMA policy H-160.903. We agree with the spirit of the resolution but agree with testimony that this internal position would not change the way the MSS already advocates for individuals experiencing homelessness. Thus, your Reference Committee recommends Resolution 216 not be adopted.

Eradicating Homelessness H-160.903

1. Our American Medical Association 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. Our AMA 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. Our AMA 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. Our AMA 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. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA 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. Our AMA 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. Our AMA 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. Our AMA 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. Our AMA:

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.

11. Our AMA 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. Our AMA:

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. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

[Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22; Appended: Res. 931, I-22; Reaffirmed in lieu of: Res. 205, A-23]

(34) RESOLUTION 306 - ADDRESSING FOOD INEQUITY FOR MEDICAL STUDENTS

RECOMMENDATION:

Resolution 306 <u>not be adopted.</u>

RESOLVED that our American Medical Association support efforts and work with relevant parties to increase access and awareness to healthy nutritional options and promote programs for medical students across the country.

VRC testimony was mainly opposed to the resolution. The Reference Committee agrees with testimony that this resolution is covered under existing AMA policies H-150.937, H-150.920, H-150.949, H-150.925, H-425.963, and D-440.919. We agree that this topic is incredibly relevant for medical students and an important avenue for advocacy, but the ask of this resolution broadly generalizes highly variable, state-dependent programs such as SNAP. While Reference Committee testimony was favorable of the spirit of the resolution, we agree with testimony that this ask is broadly covered by existing policy and outside of AMA's scope. AMA has existing policy covering concerns for work-hour qualifications for SNAP programs. Further, the variability of such programs suggests more effective advocacy can and should be pursued through other advocacy routes such as state-level advocacy through state medical societies, Local Campus Section advocacy through AMA MSOP resources, or MSSAI. Thus, your Reference Committee recommends Resolution 306 not be adopted.

Improvements to Supplemental Nutrition Programs H-150.937

1. Our American Medical Association supports:
a. improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity;
b. efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and
c. the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to:
a. incentivize healthful foods and disincentivize or eliminate unhealthful foods; and
b. harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives. [Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18; Reaffirmed: Res. 259, A-23]

Strengthening Supplemental Nutrition Assistance Program (SNAP) H-150.920

1. Our American Medical Association will support allowing the use of SNAP benefits to purchase hot, heated, and prepared foods at SNAP-eligible vendors.
2. Our AMA support expanding SNAP to U.S. territories that currently receive capped block grants for nutrition assistance.
3. 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.
4. Our AMA advocate for increased federal funding for the Supplemental Nutrition Assistance Program (SNAP) that improves and expands benefits and broadens eligibility.
[Res. 259, A-23]

Healthful Food Options in Health Care Facilities H-150.949

1. Our American Medical Association encourages healthful food options be available, at reasonable prices and easily accessible, on the premises of health care facilities.
2. Our AMA hereby calls on all health care facilities to improve the health of patients, staff, and visitors by:

a. Providing a variety of healthy food, including plant-based meals, and meals that are low in saturated and trans fat, sodium, and added sugars.
b. Eliminating processed meats from menus.
c. Providing and promoting healthy beverages.

3. Our AMA hereby calls for health care facility cafeterias and inpatient meal menus to publish nutrition information.
4. Our AMA will work with relevant stakeholders to define “access to food” for medical trainees to include overnight access to fresh food and healthy meal options within all training hospitals.

[Res. 410, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 406, A-17; Modified: Res. 425, A-18; Modified: Res. 904, I-19; Appended: Res. 304, A-21]

Food Environments and Challenges Accessing Healthy Food H-150.925

1. Our American Medical Association encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts.
2. Our AMA recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color.
3. Our AMA supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food.
4. Our AMA will advocate for CMS and other relevant agencies to develop, test, and then implement evidence-based innovative models to address food insecurity, such as food delivery and transportation services to supermarkets, food banks and pantries, and local farmers markets for healthy food options.

[Res. 921, I-18; Modified: Res. 417, A-21; Appended: Res. 117, A-22]

Food Insecurity Among Patients with Celiac Disease, Food Allergies, and Food Intolerance H-425.963

Our American Medical Association supports federal and state efforts to increase the affordability and quality of food alternatives for people with celiac disease, food allergies, and food intolerance.

Our AMA supports federal and state efforts to extend requirements for mandatory nutrient fortification to food alternatives for people with celiac disease, food allergies, and food intolerance.

Our AMA supports efforts to expand nutrition assistance eligibility and benefits to equitably meet the needs of households affected by celiac disease, food allergies, and food intolerance and increase access to food alternatives for people with celiac disease, food allergies, and food intolerance, including, but not limited to, efforts by food banks and pantries, food delivery systems, and prescription produce programs. [Res. 910, I-24]

Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs D-440.919
Our AMA: (1) supports reduction and elimination of work requirements applied to the used as eligibility criteria in public assistance programs, including the Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families Program (TANF); (2) supports states' ability to expand eligibility for public assistance programs beyond federal standards, including automatically qualifying individuals for a public assistance program based on their eligibility for another program; and (3) will work with state medical societies to encourage states to establish express lane eligibility (ELE) programs that use eligibility data from the maximum number of Express Lane Agencies (ELAs) feasible, which include SNAP, TANF, and other programs as described by the Centers for Medicare & Medicaid Services, to facilitate enrollment in Medicaid and the Children's Health Insurance Program (CHIP). [Res. 215, A-21]

(35) RESOLUTION 307 - INTERNATIONAL RECOGNITION OF DOCTORS OF OSTEOPATHY

RECOMMENDATION:

Resolution 307 <u>not be adopted.</u>

RESOLVED, that our American Medical Association supports international recognition of US-licensed Doctors of Osteopathy as medical physicians with a licensure equivalent to a MD of the same residency specialty.

VRC testimony was mainly opposed to the resolution. The Reference Committee agrees with concerns that the AMA has existing policies H-405.951 and H-405.969 which support DO parity and additional policy would not result in further advocacy. Additionally, we believe the ask of this resolution is not within the AMA's scope as a national organization because the resolution asks for international recognition. Your MSS Reference Committee would like to note that the resolution lacks strong evidence and is not backed by peer-reviewed sources. Thus, your Reference Committee recommends Resolution 307 not be adopted.

Definition and Use of the Term Physician H-405.951

1. Our American Medical Association Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Our AMA will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:

a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician.
b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician.
c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.

3. Our AMA urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Our AMA ensures that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. Our AMA will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (*JAMA*) Editorial Governance Plan, which protects the editorial independence of *JAMA*.
7. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign

[Res. 214, A-19; Reaffirmation I-22; Reaffirmed: Res. 260, A-23]

Definition of a Physician H-405.969

1. Our American Medical Association affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. Our AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a

"doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign. [Our American Medical Association affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.

[CME Rep. 4-A-94; Reaffirmed by Sub. Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Res. 846, I-08; Reaffirmed in lieu or Res. 235, A-09; Reaffirmed: Res. 821, I-09; Appended: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-13Reaffirmation A-15; Reaffirmed in lieu of: Res. 225, A-17; Reaffirmed: Res. 228, A-19; Reaffirmation I-22; Reaffirmation: Res. 211, A-24]

(36) RESOLUTION 308 - INCLUDING INCARCERATED PATIENT CARE IN MEDICAL EDUCATION

RECOMMENDATION:

Resolution 308 <u>not be adopted.</u>

RESOLVED, that our American Medical Association support medical schools and graduate medical education programs in their efforts to establish or expand opportunities for exposure to correctional healthcare, including clinical rotations in correctional facilities and partnerships with individuals that have received or been involved in the provision of carceral care, e.g., formerly incarcerated persons, physicians with fellowship training in correctional medicine, correctional officers, etc., and be it further

RESOLVED, that our AMA support academic medical centers in conducting self-reviews of their carceral health learning environments and the adherence of these to existing AMA policies regarding provision of high-quality, anti-bias health care services to incarcerated persons, such that reported provision of substandard care and normatively judgmental institutional cultures are not modeled to and disseminated to, respectively, current trainees and future generations of physicians.

VRC testimony was mainly opposed to the resolution. The Reference Committee agrees with concerns that existing AMA policies H-295.874, H-430.986, and D-430.993 support medical education and incarcerated care. Additionally, we agree with testimony that the asks of this resolution are outside the AMA’s scope and there is a lack of strong evidence presented. Thus, your Reference Committee recommends Resolution 308 not be adopted.

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874

Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models. [CME Rep. 11, A-06; Reaffirmation A-11; Modified in lieu of Res. 908, I-14; Reaffirmed in lieu of Res. 306, A-15; Reaffirmed: BOT Rep. 39, A-18; Modified: CME Rep. 01, A-20]

Health Care While Incarcerated H-430.986

1. Our American Medical Association advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons’ timely access to mental health, drug and residential rehabilitation facilities upon release.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system

and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community…
[CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21; Modified: Res. 127, A-22; Appended: Res. 244, A-23; Appended: Res. 429, A-23; Reaffirmed: BOT Rep. 05, I-24; Appended: Res. 916, I-24; Appended: Res. 918, I-24]

Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections D-430.993

Our American Medical Association supports the development of:

1. Best practices for acute care of patients in the custody of law enforcement or corrections.
2. Clearly defined and consistently implemented processes between health care professionals and law enforcement that:

a. can best protect patient confidentiality, privacy, and dignity while meeting the needs of patients, health professionals, and law enforcement and
b. ensures security measures do not interfere with the capacity to provide medical, mental health, pregnancy, end of life care, palliative care, and substance use care, especially in emergency situations, and

3. If conflict arises during an incarcerated individual's hospitalization that the hospital's bioethics committee should convene to address the issue and not a law enforcement liaison.

2. Our AMA affirms that:

1. the adoption of best practices in the acute care of patients in the custody of law enforcement or corrections is an important effort in achieving overall health equity for the U.S. as a whole.
2. it is the responsibility of the medical staff to ensure quality and safe delivery of care for incarcerated patients.
3. Our AMA supports universal coverage of essential health benefits for all individuals in the custody of law enforcement or corrections and who are incarcerated.
4. Our AMA will work with interested parties, including but not limited to, the American College of Emergency Physicians and the American College of Correctional Physicians, to develop model federal legislation requiring health care facilities to inform patients in custody about their rights as a patient under applicable federal and state law.

[Res. 407, A-22; Modified: CSAPH Rep. 06, A-23; Reaffirmed: CSAPH Rep. 4, I-23]

(37) RESOLUTION 323 - SUPPORT FOR THE ETHICAL SOURCING OF ANATOMY DISSECTION IMAGES

RECOMMENDATION:

Resolution 323 <u>not be adopted.</u>

RESOLVED, that our American Medical Association support the reevaluation of dissection illustrations used in anatomy curriculums and encourages the replacement of illustrations derived from the Pernkopf and Spanner atlases with comparable ethically sourced alternatives where possible and acknowledgment of such sources where these illustrations are unavoidable in education.

VRC testimony was mainly opposed. The Reference Committee agrees with concerns that te resolution lacks sufficient evidence to establish the prevalence of this problem and the ask is outside the AMA's scope since it deals with curricular reform. We agree with testimony that the resolve clause is broadly covered under existing AMA policy H-140.820 and the AMA Code of Ethics E-7.2.2. Thus, your Reference Committee recommends Resolution 323 not be adopted.

Addressing the Historical Injustices of Anatomical Specimen Use H-140.820

1. Our American Medical Association advocates to AAMC (Association of American Medical Colleges), AACOM (American Association of Colleges of Osteopathic Medicine), and other appropriate bodies for the return of human remains to living family members or Tribes in the case of American Indian/Alaska Native specimens, or, if none exist, the burial of anatomical specimens older than 2 years where consent for permanent donation cannot be proven, with Tribal consultation in the case of American Indian/Alaska Native specimens to ensure that all Tribal burial protocols are followed.
2. Our AMA advocates that medical schools and teaching hospitals in the US review their anatomical collections for remains of American Indian, Hawaiian Native, and Alaska Native remains and immediately return remains and skeletal collections to tribal governments, as required by laws such as the Native American Graves and Repatriation Act, and that our AMA encourage advocacy for federal funds and technical assistance for repatriation.
3. Our AMA recognizes the disproportionate impact that anatomical specimen collections have had on American Indian, Hawaiian, Alaska Native, Black American, individuals with disabilities, and other historically marginalized groups.
4. Our AMA will seek legislation or regulation that requires the return of anatomic specimens of American Indian, Hawaiian Natives, Alaskan Natives and other minority groups.
5. Our AMA supports the creation of a national anatomical specimen database that includes registry demographics.
6. Our AMA will study and develop recommendations regarding regulations for ethical body donations including, but not limited to guidelines for informed and presumed consent; care and use of cadavers, body parts, and tissue.
7. Our AMA believes that, for purpose of differentiation and clarity, anatomical specimens, tissues and other human material that were

collected and maintained for purposes of diagnosis and compliance under Clinical Laboratory Improvement Act (CLIA) where informed consent for such has been obtained, and that biospecimens donated for research, education, and transplantation where informed consents of donors (or if deceased, next of kin if available) for such has been obtained, as such materials can advance medical knowledge, improve the quality of healthcare and save lives.
[Res. 017, A-24]

7.2.2 Release of Data from Unethical Experiments
Research that violates the fundamental principle of respect for persons and basic standards of human dignity, such as Nazi experiments during World War II or from the US Public Health Service Tuskegee Syphilis Study, is unethical and of questionable scientific value. Data obtained from such cruel and inhumane experiments should virtually never be published. If data from unethical experiments can be replaced by data from ethically sound research and achieve the same ends, then such must be done. In the rare instances when ethically tainted data have been validated by rigorous scientific analysis, are the only data of such nature available, and human lives would certainly be lost without the knowledge obtained from the data, it may be permissible to use or publish findings from unethical experiments.
Physicians who engage with data from unethical experiments as authors, peer reviewers, or editors of medical publications should:
(a) Disclose that the data derive from studies that do not meet contemporary standards for the ethical conduct of research.
(b) Clearly describe and acknowledge the unethical nature of the experiment(s) from which the data are derived.
(c) Provide ethically compelling reasons for which the data are being released or cited, such as the need to save human lives when no other relevant data are available.
(d) Pay respect to those who were the victims of the unethical experimentation.
AMA Principles of Medical Ethics: II,V,VII [Issued 2016]

(38) RESOLUTION 405 - SUPPORTING INFECTIOUS DISEASE PREPAREDNESS AND FUNDING

RECOMMENDATION:

Resolution 405 <u>not be adopted.</u>

RESOLVED, that the American Medical Association amend “Bolstering Public Health Preparedness H-440.892” by addition and deletion as follows:

Our AMA: (1) supports the ~~concept that~~ enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be

specifically targeted as among our nation's highest priorities; (2) supports, ~~in principle, the~~ funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies; (3) ~~encourages~~ supports hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery; (4) supports ~~flexible~~ funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas; ~~and~~ (5) ~~encourages~~ supports health departments to develop public health messaging to provide education on unexpected infectious disease.; and (6) supports research and funding of infectious disease and related field(s).

; and be it further

RESOLVED, that the AMA-MSS immediately forward this resolution to the HOD.

VRC testimony was mixed. The Reference Committee agrees that the amendments proffered to existing AMA policy will not meaningfully change AMA advocacy on infectious disease research and funding. Additionally, as pointed out in testimony on VRC, the MSS is working with relevant specialty societies on AMA Resolution 219, “Opposing Unwarranted NIH Research Institute Restructuring,” to include specific delineations that discuss infectious disease research funding. Thus, your Reference Committee recommends Resolution 405 not be adopted.

(39) RESOLUTION 411 - EXPANDING ASYLUM QUALIFICATIONS

RECOMMENDATION:

Resolution 411 not be adopted.

RESOLVED, that our American Medical Association support the expansion of asylum qualifications to include age- and gender-based violence, persecution, and fear of persecution.

VRC testimony was mainly opposed. The Reference Committee agrees with concerns that the resolution is covered under existing AMA policies H-350.957, H-440.793, and H-65.938. We agree with testimony that the language referenced in the resolved clause is

already present in the USIC Nexus and the ask of this resolution will not elicit any further AMA advocacy. Thus, your Reference Committee recommends Resolution 411 not be adopted.

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA calls for asylum seekers to receive medically-appropriate care, including vaccinations, in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
4. Our AMA supports efforts to train physicians to conduct medical and psychiatric forensic evaluations for asylum seekers.
5. Our AMA supports medical education that addresses the challenges of life-altering events experienced by asylum seekers.
6. Our AMA urges physicians to provide medically-appropriate care for asylum seekers.
7. Our AMA encourages physicians to seek out organizations or agencies in need of physicians to provide these services.
8. Our AMA encourages provision of resources to assist people seeking asylum, including social and legal services.

[Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19; Modified: BOT Rep. 08, I-24]

Mass Deportation as a Public Health Issue H-440.793

1. Our American Medical Association recognizes mass deportation of immigrants, asylum seekers, refugees, and others with or seeking an immigration benefit as a public health issue, and recognizes the long-term mental and physical health implications of deportation on individuals, families, and communities.
2. Our AMA opposes deportation of health care workers and medically vulnerable patients solely based on their documentation status.
3. Our AMA opposes the large-scale internment of individuals targeted for deportation efforts.

[Res. 931, I-24]

Guiding Principles for the Healthcare of Migrants H-65.938

1. Our American Medical Association advocates for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the "Colombo Statement."
2. Our AMA recognizes that migration status is a social determinant of health.
3. Our AMA affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration.
4. Our AMA recognizes that the enhancement of migrants' health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families.
5. Our AMA recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard.
6. Our AMA recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization's 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by

a. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.
b. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.
c. Ensuring that the social determinants of migrants' health are addressed through joint, coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.

d. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.
e. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems.
[Res. 016, A-24]

(40) RESOLUTION 414 - INTEGRATING ENVIRONMENTAL HEALTH INTO ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

Resolution 414 <u>not be adopted.</u>

RESOLVED, that our American Medical Association support the integration of environmental determinants of health within existing Electronic Health Records to monitor the health impacts of environmental hazards, streamline disease monitoring, and facilitate clinical decision-making, with an emphasis on usability, interoperability, and support for physician education and institutional adoption; and be it further

RESOLVED, that our AMA advocate for federal and institutional funding to support the integration of environmental health data into Electronic Health Records, including investment in physician training, data standardization, and cross-platform interoperability, and environmental health screening tools to capture patient risk for environmental health-related conditions, such as heat stroke, asthma, disaster experience, lead poisoning, etc.

VRC testimony was opposed to the resolution as written. The Reference Committee agrees with concerns that the resolution asks are covered by existing AMA policies H-440.813 and H-135.938. Your Reference Committee reviewed amendments posted to the VRC and concluded that any amendments to the resolution would not result in meaningful AMA advocacy and would be best handled by EMR stakeholders. Thus, your Reference Committee recommends Resolution 414 not be adopted.

Public Health Surveillance H-440.813

1. Our American Medical Association recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats.

2. Our AMA recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities.
3. Our AMA encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health.
4. Our AMA recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data.
5. Our AMA supports the CDC's data modernization initiative, including electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws.
6. Our AMA will advocate for incentives for physicians to upgrade their EHR systems to support electronic case reporting as well as incentives to submit case reports that are timely and complete.
7. Our AMA will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting.
8. Our AMA will advocate for increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments.
9. Our AMA supports data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations.

[CSAPH Rep. 1, I-19; Reaffirmed: Res. 219, A-21; Appended: Alt. Res. 402, A-21; Modified: CSAPH Rep. 2, I-21]

Global Climate Change and Human Health H-135.938

1. Our American Medical Association supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
2. Our AMA supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3.

a. Recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
b. Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public.
4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

[CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22]

(41) RESOLUTION 420 - UPDATING U.S. FOOD AND DRUG ADMINISTRATION (FDA) NUTRITION GUIDELINES

RECOMMENDATION:

Resolution 420 <u>not be adopted.</u>

RESOLVED, that our American Medical Association recommend government agencies decrease the recommended daily values of added sugars and saturated fats to reflect the most updated, evidence-based guidelines outlined by relevant specialty societies; and be it further

RESOLVED, that our AMA support the U.S. Food and Drug Administration (FDA) in developing a formal advisory program in which relevant medical specialty societies and experts are consulted at regular intervals to determine when and how nutrition guidelines should be updated.

VRC testimony was mainly opposed to the resolution. The Reference Committee agrees that the asks of the resolution are covered under existing AMA policies D-150.974 and

H-440.902. We agree with testimony that the asks of this resolution will not meaningfully change AMA policy and further action can be pursued outside of the resolution process. Thus, your Reference Committee recommends Resolution 420 not be adopted.

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974

1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.
2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA).
3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.
4. Our AMA encourages the FDA to: (a) develop front-of-package warning labels for foods that are high in added sugars based on the established recommended daily value; and (b) limit the amount of added sugars permitted in a food product containing front-of-package health or nutrient content claims. [Res. 422, A-14; Appended: Res. 903, I-18]

Obesity as a Major Health Concern H-440.902

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity. [Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Modified: Res. 402, A-17]

(42) RESOLUTION 423 - ADDRESSING PUBLIC HEALTH RISKS OF ONLINE SPORTS BETTING

RECOMMENDATION:

Resolution 423 not be adopted.

RESOLVED, that our American Medical Association support efforts such as the SAFE Bet Act to expand federal regulations surrounding consumer protections that align with the Internet Responsible Gaming Standards for online gambling and sports betting; and be it further

RESOLVED, that our AMA support federal funding for updated epidemiological studies on gambling addiction, particularly among young people; and be it further

RESOLVED, that our AMA support national data collection on the prevalence of gambling disorder and problem gambling.

VRC testimony was mixed. The Reference Committee agrees that the issue of sports betting is one that is relevant and timely; however, we agree that existing AMA policy supports the Safe BET Act. Additionally, we agree with testimony that this resolution would be better suited coming from a specialty society who has expertise in this area and can strengthen the language to elicit meaningful AMA action. Thus, your Reference Committee recommends Resolution 423 not be adopted.

(43) RESOLUTION 427 - INCREASING SUPPORT FOR GLOBAL SURGERY AND GLOBAL HEALTH EDUCATIONAL PROGRAMS

RECOMMENDATION:

Resolution 427 not be adopted.

RESOLVED, that our American Medical Association recognize global surgery as an essential component of global health; and be it further

RESOLVED, that our AMA support education and awareness of the general public and legislating bodies regarding current disparities in global surgery funding and initiatives, and advocates for funding to help establish and strengthen those programs; and be it further

RESOLVED, that our AMA collaborate with relevant parties, including CMS, ACGME, LCME, and COCA, to support efforts to establish standardized global health curricula for residency and medical school programs.

VRC testimony was opposed to the resolution as written. The Reference Committee agrees with concerns that the first two resolve clauses are covered by existing AMA policy D-305.967 and G-630.070 and the third resolve is outside the AMA's scope. Your Reference Committee reviewed amendments posted to the VRC and concluded that any

amendments to the resolution would not result in meaningful AMA advocacy and would be best handled by the relevant specialty societies. Thus, your Reference Committee recommends Resolution 427 not be adopted.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.

Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.

Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.

Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.

Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.

Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME… [Sub. Res. 314, A-07… Modified: Res. 310, A-24]

International Strategy G-630.070

1. Our American Medical Association recognizes the importance of the involvement of the medical profession in this country in influencing the

standards utilized by other nations with regard to ethics, medical education and medical practice, and the commitment to the patient-physician relationship.

2. Our AMA supports the activities of the World Medical Association (WMA) to improve health care in developing countries and supports WMA commendation of those countries that demonstrate exemplary efforts to improve health care delivery to their populations.
3. Our AMA:

a. continues to support the World Health Organization as an institution.
b. advocates full funding as understood by the United States Government for the World Health Organization.
c. will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization.
d. encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible.

4. Our AMA supports the position of the U.S. government to preserve the integrity of the World Health Organization (WHO) and opposes any attempts to politicize the WHO.
5. Our AMA will include the International Medical Graduates Section as a resource for international medical initiatives.
6. Our AMA will:

a. continue to focus its international activities on and through organizations that are multinational in scope.
b. encourage ethnic and other medical associations to assist medical education and improve medical care in various areas of the world.
c. encourage American medical institutions and organizations to develop relationships with similar institutions and organizations in various areas of the world.
d. work with the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to ensure that medical students participating in global health programs, including but not limited to international electives and summer clinical experiences are held accountable to the same ethical standards as students participating in domestic service-learning opportunities.
e. work with the AAMC to ensure that international electives provide measurable and safe educational experiences for medical students, including appropriate learning objectives and assessment methods.
f. communicate support for a coordinated approach to global health education, including information sharing between and among medical schools, and for activities, such as the AAMC Global Health Learning Opportunities (GHLOTM), to increase student participation in international electives.

7. Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the World Health Organization.

[BOT Rep. 21 and Res. 618, A-97; Consolidated: CLRPD Rep. 3, I-01; Modified: CC&B Rep. 2, A-11; Modified: CCB/CLRPD Rep. 1, A-21]

(44) RESOLUTION 429 - INCREASE CLASSROOM PHYSICAL ACTIVITY

RECOMMENDATION:

Resolution 429 not be adopted.

RESOLVED, that our American Medical Association support the use of active lessons as a replacement for sedentary classroom lessons whenever feasible and appropriate with adequate disability accommodations in primary and secondary schools as a means of increasing student physical activity, health, well-being, and attention; and be it further

RESOLVED, that our AMA study alternative classroom desk types such standing and sit-stand desks (e.g., impacts on academic performance, overall daily physical activity, and chronic disease risk) as well as other potential non-sedentary desk alternatives for individuals with disabilities who are unable to utilize the aforementioned desk types.

VRC testimony was opposed to the resolution. The Reference Committee agrees with concerns that asks of the resolution are not actionable because the primary issue presented is a school-based issue regulated at the state level. We believe the first resolved clause will not result in any meaningful AMA action and the second resolved clause is out of scope. Your Reference Committee recommends alternative routes of advocacy in lieu of additional AMA policy on this topic. Thus, your Reference Committee recommends Resolution 429 not be adopted.

(45) RESOLUTION 432 - MANDATORY GLUTEN LABELING IN MEDICATIONS, SUPPLEMENTS, AND HERBAL REMEDIES

RECOMMENDATION:

Resolution 432 not be adopted.

RESOLVED, that our American Medical Association support further research to assess the clinical impact of gluten exposure from medications in individuals with celiac disease and gluten sensitivity, evaluating whether trace amounts pose a significant health risk to warrant mandatory labeling regulations; and be it further

RESOLVED, that our AMA support efforts by the U.S. Food and Drug Administration (FDA), pharmaceutical manufacturers, and other relevant stakeholders to develop and implement standardized testing; and be it further

RESOLVED, that our AMA encourage the inclusion of allergen-related information, including gluten and wheat-derived ingredients, in electronic health records and

pharmacy dispensing systems to improve the identification of safe medications for patients with celiac disease and gluten sensitivity.

VRC testimony was mixed. The Reference Committee agrees with concerns that resolution lacks strong peer-reviewed sources. Additionally, we agree with relevant specialty society testimony that the first resolved clause lacks evidence, the second resolved clause is out of scope, and the third resolved clause is premature. Thus, your Reference Committee recommends Resolution 432 not be adopted.

(46) RESOLUTION 433 - STANDARDIZING SAFE HAVEN LAWS: ENSURING MEDICAL CARE & SUPPORT FOR SURRENDERED INFANTS

RECOMMENDATION:

Resolution 433 not be adopted.

RESOLVED, that our American Medical Association advocate for the development of a federal framework to standardize Safe Haven laws that promote robust medical protection for surrendered infants, as well as clear, safe, and equitable processes for all parties involved; and be it further
RESOLVED, that our AMA support the development of a national monitoring system to collect data on surrendered newborns, to evaluate and improve the effectiveness of Safe Haven Laws over time.

VRC testimony was mixed. While the Reference Committee agrees with testimony that this resolution covers an important issue, the ask of the resolution is better suited for state level advocacy. We agree with concerns from relevant specialty societies that the resolution lacks a clear path for implementation and may have unintended consequences in the current advocacy space. We agree with the spirit of the resolution, but we believe this ask would have the most success by pursuing advocacy at the state level. Thus, your Reference Committee recommends Resolution 433 not be adopted.

(47) RESOLUTION 438 - REDUCING AIRBORNE TRANSMISSION OF PATHOGENS

RECOMMENDATION:

Resolution 438 not be adopted.

RESOLVED, that our American Medical Association encourage the implementation evidence-based indoor air quality improvement strategies in healthcare facilities, including but not limited to enhanced ventilation and high-efficiency particulate air

(HEPA) filtration, and air disinfection methods such as Ultraviolet Germicidal Irradiation (UVGI); and be it further

RESOLVED, that our AMA support the utilization of CO2 monitoring as a proxy for ventilation adequacy in indoor spaces and encourages collaboration with relevant public health and occupational safety stakeholders to develop consistent, evidence-based guidelines for its use in mitigating airborne disease transmission.

VRC testimony was mixed. The Reference Committee agrees with concerns that the first resolved clause is covered by existing AMA policy H-440.810and lies outside of the scope of AMA advocacy, and the second resolved clause lacks sufficient evidence to support the ask. Additionally, we agree with testimony the second resolve is outside of the AMA's purview. Thus, your Reference Committee recommends Resolution 438 not be adopted.

Availability of Personal Protective Equipment (PPE) H-440.810

1. Our American Medical Association affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
3. Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.
4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.
5. Our AMA supports the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.
6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.
7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.

[Res. 412, I-20; Appended: Res. 414, A-21; Modified: Res. 410, I-21]

(48) RESOLUTION 440 - ADDRESSING HOUSING NEEDS OF THE NATIVE HAWAIIAN AND THEIR DIASPORA

RECOMMENDATION:

Resolution 440 <u>not be adopted.</u>

RESOLVED, that our American Medical Association support permanent reauthorization of the Native American Housing Assistance and Self-Determination Act (NAHASDA); and be it further

RESOLVED, that our AMA support expansion of NAHASDA to provide affordable housing to Native Hawaiians living outside Hawai'i; and be it further

RESOLVED, that our AMA support proof of Indigenous Hawaiian lineage as defined by Native Hawaiian Organizations and representatives for qualification to attain, retain, and inherit beneficiary status of the Hawaiian Homes Commission Act; and be it further

RESOLVED, that our AMA support efforts by the Department of Hawaiian Home Lands (DHHL) to meet the need for housing Native Hawaiians through the acquisition and establishment of additional trust lands and through increased funding; and be it further

RESOLVED, that our AMA support congressional efforts to hold the Department of Hawaiian Home Lands accountable to its trust responsibility to Native Hawaiians including by ensuring that its beneficiaries are the prioritized party in the utilization of any and all DHHL trust lands.

VRC testimony was mixed. The Reference Committee agrees with testimony that this resolution covers an important topic, but we agree with concerns that the asks of the resolution fall outside AMA's scope. We further agree that this resolution is covered under existing AMA policy H-160.903. Thus, your Reference Committee recommends Resolution 440 not be adopted.

Eradicating Homelessness H-160.903

1. Our American Medical Association 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. Our AMA 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. Our AMA 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. Our AMA 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. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA 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. Our AMA 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. Our AMA 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. Our AMA 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. Our AMA:

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.

11. Our AMA 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. Our AMA:

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. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

[Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22; Appended: Res. 931, I-22; Reaffirmed in lieu of: Res. 205, A-23]

(49) RESOLUTION 505 - PROMOTING PROCEDURAL POCUS USE AND AVAILABILITY

RECOMMENDATION:

Resolution 505 not be adopted.

RESOLVED, that our American Medical Association raise awareness among hospital leadership about the benefits of procedural point-of-care ultrasound (POCUS) utilization and encourage hospitals to utilize available funding for the acquisition and maintenance of POCUS machines; and be it further

RESOLVED, that our AMA work with specialty societies relevant to inpatient practice to develop improved guidance related to the billing and reimbursement of POCUS in inpatient settings; and be it further

RESOLVED, that our AMA encourage hospitals to create an environment where point-of-care-ultrasound machines can be broadly used, including outside of the emergency department and intensive care unit, for procedural use in the event of patient care emergencies.

VRC testimony was opposed to the resolution. The Reference Committee agrees with concerns that the first and third resolved clauses are outside the AMA's scope and the second resolved clause is not a feasible avenue for AMA advocacy efforts at this time. Your Reference Committee would like to note that a similar resolution was submitted to the 2024 MSS Interim Meeting and was not adopted due to concerns from relevant specialty societies that apply to this resolution as well. Thus, your Reference Committee recommends Resolution 505 not be adopted.

(50) RESOLUTION 508 - ENSURING ENVIRONMENTAL SUSTAINABILITY IN AI APPLICATIONS

RECOMMENDATION:

Resolution 508 not be adopted.

RESOLVED, that our American Medical Association study mechanisms / create guidelines for the responsible use of AI that mitigates the environmental impacts of AI infrastructure and use, including the consideration of:

(a) moratoria on the construction of new data centers without comprehensive assessments of their long-term environmental and socioeconomic impacts.
(b) opposition to tax incentives for technology companies engaged in these practices that shift infrastructure costs onto consumers and taxpayers.
(c) supporting the development of environmental regulations on AI infrastructure (including data centers), including independent assessments of energy sources, to limit excessive energy consumption, water use, noise pollution, and emissions.

VRC testimony was mixed. The Reference Committee agrees with concerns that the AMA has existing policy supporting environmental sustainability in AI and this resolution is outside the scope of the AMA. We agree with testimony that the resolution does not specifically or adequately prove that this issue is tied to health care outcomes. Thus, your Reference Committee recommends Resolution 508 not be adopted.

(51) RESOLUTION 509 - REMOVING BARRIERS FOR OPEN ACCESS TO MEDICAL RESEARCH

RECOMMENDATION:

Resolution 509 <u>not be adopted.</u>

RESOLVED, that our American Medical Association amend Policy D-478.964, “The High Cost to Authors for Open Access Peer Reviewed Publications,” by addition and deletion to read as follows; and be it further

The High Cost to Authors for Open Access Peer Reviewed Publications, D-478.964
Our AMA ~~Board of Trustees~~ <u>collaborate with relevant stakeholders to advocate for improving accessibility, transparency, and equity in both publishing and accessing research by:</u>
<u>(a) supporting policies and legislation ensuring immediate, barrier-free public access to publications and data resulting from publicly funded medical research;</u>
<u>(b)</u>, ~~will~~ continue<u>ing</u> to monitor the Federal Trade Commission’s actions in relation to predatory publishers and will disseminate the information to our AMA members;
<u>(c) supporting the exploration of emerging models of research dissemination that could reduce costs, enhance quality, and improve accessibility, including the potential use of blockchain technology for transparent and decentralized publication processes, as well as open peer-review systems while upholding rigorous peer-review and publication standards;</u>
<u>(d) providing practical guidance to AMA members on navigating open-access publishing, including how to legally share research under funder mandates and publisher policies, properly use Creative Commons (CC</u>

BY) licenses, and self-archive manuscripts in compliance with open-access requirements, through AMA's website and educational materials;
(e) supporting policies that promote fair, sustainable, and non-exploitative open-access publishing models that remove barriers to knowledge dissemination for both authors and readers;
(f) and supporting efforts to maintain and expand Health Sciences Libraries at a level that ensures adequate learning resources for the present and future.

RESOLVED, that our American Medical Association rescind Policy H-215.987, "Elimination of Hospital Medical Library."

VRC testimony was mixed between referral and support with amendments. Your Reference Committee agrees with testimony that this resolution lacks a thorough review and presentation of resources; the whereas clauses do not provide a strong argument for the asks of the resolved clauses. Staff is already working to address the barriers outline in this resolution based on a previously submitted MSSAI and the drafting of this resolution. We believe the asks of this resolution can be accomplished outside the resolution writing process. Thus, your Reference Committee recommends Resolution 509 not be adopted.

(52) CHIT REPORT - EMERGENCY PREPAREDNESS IN EHR DOWNTIME AND HEALTHCARE TECHNOLOGY DISRUPTIONS

RECOMMENDATION:

CHIT Report not be adopted.

Your Committee on Health Information Technology recommends that the following recommendations are adopted in lieu of Resolution 503 and the remained of this report be filed:
RESOLVED, that our American Medical Association support indemnity or other liability protections for physicians who are victims of technology failures, or whose patients are harmed by systemic technology failures that could not have been prevented through reasonable cybersecurity measures.

VRC testimony was mixed between support and re-referral. The Reference Committee agrees with concerns that the recommendations of this report lack a strong evidentiary basis, and we acknowledge that this is due to the lack of literature. We believe the whereas clauses do not adequately support the report's recommendation and additionally believe the report should not be re-referred due to the lack of literature. Thus, your Reference Committee recommends CHIT Report not be adopted.

RECOMMENDED FOR FILING

(53) GC REPORT E - MSSAI REPORT

RECOMMENDATION:

GC Report E be filed.

Your MSS Governing Council recommends this report be filed.

VRC testimony was supportive. Your Reference Committee thanks the MSS Governing Council for outlining the MSSAIs taken on by the GC since the 2024 MSS Interim Meeting. Your Reference Committee recommends GC Report E be adopted and the remainder of this report be filed.

(54) SD REPORT A - DELEGATE REPORT: POLICY PROCEEDINGS OF THE INTERIM 2024 HOUSE OF DELEGATES MEETING

RECOMMENDATION:

SD Report A be filed.

Your MSS Section Delegates recommend the adoption of the recommendations for MSS positions outlined in Appendices A and B of this report and the remainder of the report be filed.

VRC testimony was supportive. Your Reference Committee thanks the MSS Section Delegates for a thorough and concise report on I-24 proceedings. We agree with testimony that this report is well-written and comprehensive. Your Reference Committee recommends SD Report A be filed.