Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. Resolution 001 - Tribal Public Health Authority
2. Resolution 016 - Medicaid Hearing Coverage
3. Resolution 031 - Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training
4. Resolution 049 - Amend Civil and Human Rights H-65.959 to Increase Protections
5. Resolution 054 - Expanded Housing Voucher Anti-Discrimination Protections
6. Resolution 063 - Ground Ambulance Services and Surprise Billing
7. Resolution 071 - Addressing Medical Misinformation Online
8. Late Resolution 001 - Sunset Report Update
10. CEQM MIC Report A - Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation

**RECOMMENDED FOR ADOPTION AS AMENDED**

11. Resolution 002 - Amendment to AMA Policy "Firearms and High-Risk Individuals H-145.972" to Include Medical Professionals as a Party Who Can Petition the Court
12. Resolution 003 - Purchased and Referred Care Expansion
13. Resolution 011 - Tribal Health Program Electronic Health Record Modernization
15. Resolution 014 - Indian Health Service Graduate Medical Education
16. Resolution 018 - Estrogen as a risk factor for stroke in patients with migraine with aura
17. Resolution 028 - Including Gender Inclusive Language in Menstrual Healthcare
18. Resolution 033 - The Health Care Related Effects of Recent Changes to the US Mexico Border
19. Resolution 034 - Conservatorship and Guardianship Reform
20. Resolution 035 - Advocating for the Regulation of Waste Products in Industrialized Farming
21. Resolution 036 - Emergency Anti-Epileptic Interventions
22. Resolution 038 - Studying Population-Based Payment Policy Disparities
23. Resolution 039 - School-to-Prison Pipeline
24. Resolution 044 - Environmental Health Equity in Federally Subsidized Housing
25. Resolution 046 - Encouraging Increased Accessibility and Utilization of Occupational Pulmonary Lung Disease Screenings
26. Resolution 047 - Increasing Diversity in Stem Cell Biobanks and Disease Models
27. Resolution 051 - Providing Modest Attire Options at Hospitals for Patients and Employees
29. Resolution 060 - Elective Personal Finance Curriculum in Medical Education
30. Resolution 062 - Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants
32. Resolution 068 - Increasing regulation and labeling of fragrances in personal care products, cosmetics, and drugs
33. Resolution 079 - Support and Advocacy for Permanent Standard Time
34. IOPTF Report- Internal Operating Procedures Task Force Report
35. CEQM WIM Report A - Expansion of Medicaid Coverage of HPV Screening

RECOMMENDED FOR ADOPTION IN LIEU OF

36. Resolution 004 – Increased Education and Access to Fertility Resources for U.S. Medical Students
37. Resolution 027 - Recognition of the Disproportionate Impact of Infertility on Physicians
38. Resolution 012 - Amend Preventing Resident Physician Suicide 310.054MSS to Include Annual Opt-out Mental Health Screening for Suicide Prevention
39. Resolution 015 - Preventing Human Papillomavirus (HPV) infection and HPV-associated cancers in people who are incarcerated
40. Resolution 017 - AMA opposition of heartbeat laws which indicate first evidence of embryonic cardiac activity as presence of fetal heartbeat
41. Resolution 020 - Lack of Access to Abortion is a Threat to Public Health
42. Resolution 029 - Naloxone Alternatives or Adjuncts to Combat Synthetic Opioid-Induced Respiratory Depression
43. Resolution 032 - Addressing the Impact of Medicare Transition on Spousal Healthcare
44. Resolution 055 - Advocating for access to safer smoking kits as part of harm reduction services
45. Resolution 061 - Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement
44. | Resolution 006 - Medicaid Managed Care for Indian Health Care Providers

45. | Resolution 007 - Increased Health Privacy on Mobile Apps in Light of Roe v. Wade

46. | Resolution 009 - New Policies to Respond to the Gun Violence Public Health Crisis

47. | Resolution 010 - Against Direct Contracting Entities

48. | Resolution 019 - Regulation of Skin Bleaching Agents and Colorism as a Public Health Concern

49. | Resolution 022 - Amending Policy H-80.999, “Sexual Assault Survivors” to Improve Knowledge and Access to No-cost Rape Test Kits

50. | Resolution 025 - Studying Effects of Online Education on Medical Education Outcomes during COVID-19 Pandemic

51. | Resolution 026 - Special Diabetes Program for Indians

52. | Resolution 030 - Research of Plastic Use in Medicine

53. | Resolution 042 - Advocating for Health Coverage Expansion for Post-COVID (Long-COVID) Conditions

54. | Resolution 045 - Increase Resident Physician Pay

55. | Resolution 085 - Against Legacy Preferences as a Factor in Medical School Admissions

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57. | Resolution 005 - Advocating for Utilization of State-level Waivers in Post-COVID-19 Coverage Protection

58. | Resolution 023 - Specialized Psychiatric Facilities for Pregnant and Postpartum Individuals

59. | Resolution 024 - Billing for Traditional Healing Services

60. | Resolution 040 - Changing Medical School Drug Testing Policies

61. | Resolution 043 - Researching New CCHD Screening Practices in Pigmented Neonates

62. | Resolution 048 - Discussions on Elective Sterilization in Undergraduate Medical Education

63. | Resolution 052 - Improving Cardiovascular Screenings By Including Lipoprotein(a) (Lp(a))

64. | Resolution 053 - Ensuring Basic Ophthalmology Training in Medical Education

65. | Resolution 056 - Ensuring Fair Opportunities for International Medical Students

66. | Resolution 057 - Use of ICD and CPT Codes to Improve Response to Human Trafficking
67. Resolution 059 - Support for Medicare Expansion to Wheelchair Accessibility
   Home Modifications as Durable Medical Equipment
68. Resolution 067 - Introduction of Pre-discharge Individualized Fall Risk
   Assessments for Older Adults
69. Resolution 072 - Sleep Deprivation as a Public Health Crisis
70. Resolution 074 - Encouraging the Transition from Artificial Turf to Natural Grass
   Surfaces for Athletic Use
71. Resolution 078 - Mental Health Protocols for Surgery
72. Resolution 080 - Amend AMA-MSS 65.017 to Expand LGBTQ+ Health Training
73. Resolution 081 - Establishment of a Climate Change Standing Committee
74. Resolution 083 - Establishing and Maintaining Patient Libraries in Hospitals

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

75. Resolution 008 - Supporting Legislative and Regulatory Efforts against Fertility
   Fraud
76. Resolution 021 - Support Further Intervention in Caregiver Support for End-of-
   Life Patients
77. Resolution 037 - Gender Pronoun Use in Medical Education
78. Resolution 041 - Supporting Research into Heat Response Plans
79. Resolution 050 - Waste Receptacles in All Restroom Stalls for Menstrual Product
   Disposal
80. Resolution 065 - Expanding Medical Nutrition Therapy Coverage in Medicare and
   Medicaid Plans
81. Resolution 066 - Increased regulation of commercial electric scooter use
82. Resolution 069 - Enabling Transmission of Third-Party Data and Metadata to
   Electronic Health Records
83. Resolution 070 - School Based Mental Health Programs for Children Exposed to
   Gun Violence
84. Resolution 073 - Decreasing the Burden of Out-of-Pocket Costs for Biologic
   Therapies
85. Resolution 075 - Mitigating Barriers Faced by Muslim Healthcare Workers
86. Resolution 076 - Emphasizing and Expanding Sun Protection Lessons in K-12
   Children
87. Resolution 077 - Amending Existing Preventative Policy to Decrease
   Comorbidities in Patients with Developmental Disabilities
88. Resolution 082 - Amendment to AMA Policy Sharing of Medical Disciplinary Data
   Among Nations D-275.975
89. Resolution 084 - Combating Antimicrobial Resistance through
   Ethnopharmacology
RECOMMENDED FOR ADOPTION

(1) RESOLUTION 001 - TRIBAL PUBLIC HEALTH AUTHORITY

RECOMMENDATION:

Resolution 001 be adopted.

RESOLVED, Our AMA advocate to achieve enactment of reforms to reaffirm American Indian and Alaska Native Tribes and Tribal Epidemiology Centers’ status as public health authorities; and be it further

RESOLVED, Our AMA make a suggestion to the Department of Health and Human Services to develop sub-agency (e.g, CDC, IHS) guidance on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers; and be it finally

RESOLVED, Our AMA encourages the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers.

VRC testimony was supportive. The Reference Committee agrees with testimony that this resolution is well-written and will advance the AMA's advocacy to uphold tribal sovereignty by promoting equitable access to public health data. Your Reference Committee recommends Resolution 001 be adopted.

(2) RESOLUTION 016 - MEDICAID HEARING COVERAGE

RECOMMENDATION:

Resolution 016 be adopted.

RESOLVED, That our AMA amend H-185.929 by addition to read as follows:

Hearing Aid Coverage H-185.929
1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.

4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare’s Benefit.

5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.

6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.

7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.

8. Our AMA advocate that hearing exams, hearing aids, cochlear implants, and aural rehabilitative services be covered in all Medicaid programs and any new public insurance programs

VRC testimony was overall supportive. The Reference Committee agrees with testimony that this resolution is extremely feasible and timely as hearing aids are now accessible over-the-counter. The Reference Committee recommends adoption of this resolution so that this language can be sent with other MSS transmittals on Medicaid dental and vision coverage. Changes to the market with over-the-counter hearing aids were noted in testimony but are likely still not affordable for those with Medicaid. While USPSTF may not recommend hearing screening for older adults, this is not the entire Medicaid population, and the policy as written specifies hearing exams. Testimony noted that “new public insurance programs” was warranted and added considerable flexibility in applying the policy. Your Reference Committee recommends Resolution 016 be adopted.

(3) RESOLUTION 031 - EXPANDING INCLUSION OF DIVERSE MANNEQUINS USED IN CPR AND AED TRAINING

RECOMMENDATION:

Resolution 031 be adopted.

RESOLVED, Our AMA supports use of diverse mannequins in CPR and AED training, including, but not limited to, mannequins with breasts, mannequins representing pregnant persons, mannequins representing persons with disabilities, and mannequins of varying body sizes; and be it further

RESOLVED, Our AMA supports the efforts of relevant stakeholders to develop diverse mannequins or modify current mannequins to reflect diverse patient populations, including, but not limited to, those representing pregnant persons or persons with physical disabilities; and be it further
RESOLVED, Our AMA will collaborate with relevant stakeholders to increase accessibility of CPR and AED training equipment representing diverse gender and body types in basic life support and advanced certified life support programs nationwide to ensure optimal competency for trainees of all education levels.

VRC testimony was supportive. The Reference Committee agrees with testimony that this resolution should be adopted as is. An amendment was proposed to strike the second and third resolves due to potential redundancy, however the reference committee found them to address novel portions of the device creation process. We discussed that each resolve is novel because they address increased access, development, and use respectively. The Reference Committee recommends Resolution 031 be adopted.

(4) RESOLUTION 049 - AMEND CIVIL AND HUMAN RIGHTS H-65.959 TO INCREASE PROTECTIONS

RECOMMENDATION:

Resolution 049 be adopted with a title change.

TITLE: Opposing Mandated Reporting of LGBTQ+ Status

RESOLVED, That our AMA amend Policy H-65.959, “Opposing Mandated Reporting of People Who Question Their Gender Identity” as follows:

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

Our AMA opposes mandated reporting of individuals who identify as part of the LGBTQ+ community and those who question or express interest in exploring their gender identity and/or sexual orientation.

VRC testimony was supportive of the spirit. The Reference Committee agrees with testimony that suggests a title change to match the amended policy. GLMA supports the resolution and title change. Your Reference Committee recommends Resolution 049 is novel and should be adopted with a title change.

(5) RESOLUTION 054 - EXPANDED HOUSING VOUCHER ANTI-DISCRIMINATION PROTECTIONS

RECOMMENDATION:

Resolution 054 be adopted.
RESOLVED, That our AMA support local, state, and federal policies requiring landlords to accept Section 8 and related housing vouchers as valid sources of individual and family income; and be it further

RESOLVED, That our AMA support local, state, and federal policies preventing landlords from discriminating against individuals and families who utilize public assistance.

VRC testimony was supportive. The Reference Committee agrees with testimony that this resolution is well-researched and has feasible resolves. We agree that this resolution offers novelty in addressing housing discrimination as an important social determinant of health that affects public health outcomes. While there were concerns in VRC testimony for the inclusion of requiring landlords to accept Section 8 as a purely economic stance, your Reference Committee sees this concept as novel with clear support in the argument and within the scope of the AMA to advocate on this issue. The Reference Committee recommends adoption of Resolution 054.

(6) RESOLUTION 063 - GROUND AMBULANCE SERVICES AND SURPRISE BILLING

RECOMMENDATION:

Resolution 063 be adopted.

RESOLVED, That our AMA oppose surprise billing practices for ground ambulance services.

VRC testimony was supportive with amendments. The Reference Committee agrees with testimony that this resolution is novel and should be adopted instead of added as an amendment to existing policy to strengthen the AMA’s advocacy efforts. The No Surprises Act has included air ambulance services but notably excluded ground ambulances. The Reference Committee recommends Resolution 063 be adopted.

(7) RESOLUTION 071 - ADDRESSING MEDICAL MISINFORMATION ONLINE

RECOMMENDATION:

Resolution 071 be adopted.

RESOLVED, That AMA policy D-440.915 be amended by addition and deletion as follows:

Medical and Public Health Misinformation in the Age of Social Media Online D-440.915
Our AMA:
(1) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information;
(2) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms;
(3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and
(4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

VRC testimony was limited and supportive. The Reference Committee agrees with testimony that this resolution is novel and improves the AMA’s advocacy efforts. The Reference Committee discussed the terminology and scope of the language used in this amendment, and ultimately concluded that it was necessary and comprehensive of entities that the AMA should encourage to address misinformation. Your Reference Committee recommend Resolution 071 be adopted.

(8) LATE RESOLUTION 001 – SUNSET REPORT UPDATE

RECOMMENDATION:

Late Resolution 001 be adopted.

RESOLVED, That our AMA-MSS retain all MSS policies due to be rescinded at the Interim 2022 MSS Assembly; and be it further

RESOLVED, That the AMA-MSS Governing Council review all policies retained by the Interim 2022 MSS Assembly and prepare a sunset report for the Annual 2023 MSS Assembly, in accordance with the sunset mechanism outlined in 630.044MSS.

Your Reference Committee thanks the authors for the late resolution and for attention to our MSS policies. Your Reference Committee recommends Late Resolution 001 be adopted.
(9) DELEGATE REPORT A - STATUS OF PENDING MSS-AUTHORED RESOLUTIONS TO THE HOUSE OF DELEGATES

RECOMMENDATION:

The Recommendations of Delegate Report A be adopted and the remainder of the report filed.

Your Section Delegates recommend that the following resolutions be discharged from the transmittal queue:

1. 60 Anti-Harassment Training
2. 62 Mental Health First Aid Training
3. 93 Incorporating the Evidence-Based Concepts of the Choosing Wisely Program into Undergraduate and Graduate Medical Education
4. 76 Banning LGBTQ+ Panic Defenses

Your Section Delegates further recommend that the following resolutions be combined:

1. Addressing the Use of Mail-order Naloxone to Curb the Opioid Epidemic to Access to Naloxone for Vulnerable and Underserved Populations (New Title: Access to Naloxone for Vulnerable and Underserved Populations)

Your Section Delegates further recommend the following resolutions change its title:

1. 195 Comparative Effectiveness Research to Study Integrating Comparative Effectiveness Research into the FDA Approval Process

Your Section Delegates further recommend that the following resolutions be held in the queue for the duration of the current meeting being due to other ongoing movement on related items:

1. 134 Movement Away from Employer-Sponsored Health Insurance
2. 160 Support of Vision Screenings and Visual Aids for Adults Covered by Medicaid
3. 107 Abolishment of the Resolution Committee
4. 127 Supporting Daylight Saving Time as the New, Permanent Standard Time
5. 143 Amending Policy on a Public Option to Maximize AMA Advocacy
6. 206 Indian Health Service Licensure Exemptions

There was no VRC testimony on Delegate Report A. The Reference Committee would like to thank the Section Delegates for a lovely report. Your Reference Committee recommends the recommendations of Delegate Report A be adopted.

(10) CEQM MIC REPORT A- LAYING THE FIRST STEPS TOWARDS A TRANSITION TO A FINANCIAL AND CITIZENSHIP NEED BLIND MODEL FOR ORGAN PROCUREMENT AND TRANSPLANTATION

RECOMMENDATION:
The Recommendations of CEQM MIC Report A be **adopted** and the remainder of the report **filed**.

Your Minority Issues Committee and Committee on Economics and Quality in Medicine recommend that the following recommendations be adopted and the remainder of the report be filed:

1) That the first resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

   **RESOLVED,** That our AMA support and advocate for federal laws initiatives that remove decrease financial and institutional barriers to organ transplantation to uninsured or insurance-ineligible recipients, such as provisions for expenses involved in the transplantation of organs incurred by the uninsured regardless of a legally defined United States Citizenship and Immigration Service (USCIS) immigration status, excluding medical tourism as defined in the AMA code of ethics 1.2.13 in the country as long as the person can show physical presence in the U.S. prior to needing the organ; and **be it further**

2) That the second resolved clause of MSS Resolution 46 be adopted.

3) That the third resolved clause of MSS Resolution 46 be adopted.

4) That the following clause be adopted in lieu of the fourth resolved clause of MSS Resolution 46:

   **RESOLVED,** That the AMA Council on Ethical and Judicial Affairs reconsider its Guidelines for Organ Transplantation from Deceased Donors to consider the concerns of differential access based upon immigration status; and **be it further**

5) That the fifth resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

   **RESOLVED,** That our AMA amend H-370.982 to also clarify its stance of not regarding immigration status as long as the person lives in the U.S. thereby keeping the overall equitability of the system for organ donation and receiving parties intact by addition to read as follows:

   **Ethical Considerations in the Allocation of Organ and Other Scarce Medical Resources Among Patients, H-370.982**
Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment without regard to a legally defined United States Citizenship and Immigration Service (USCIS). In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, immigration status, perceived obstacles to treatment or follow-up, patient contribution to illness, or past use of resources should not be considered.

(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.
(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.

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

VRC testimony was supportive. The Reference Committee agrees with testimony from the American Society of Transplant Surgeons that the report is well-researched. The report removes resolved clauses that are outside of the scope of AMA and amends asks to be actionable and inclusive. Your Reference Committee recommends the Recommendations of CEQM MIC Report A be adopted.
RECOMMENDED FOR ADOPTION AS AMENDED

(11) RESOLUTION 002 - AMENDMENT TO AMA POLICY “FIREARMS AND HIGH-RISK INDIVIDUALS H-145.972” TO INCLUDE MEDICAL PROFESSIONALS AS A PARTY WHO CAN PETITION THE COURT

RECOMMENDATION A:

The third Resolve of Resolution 002 be amended by addition and deletion:

RESOLVED, That our AMA supports amending policy “Firearms and High-Risk Individuals H-145.972” by addition to read:

Firearms and High-Risk Individuals H-145.972
Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, medical professionals, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) the establishment of laws and procedures through which physicians can, in partnership with appropriate stakeholders, contribute to the inception and development of such petitions; (23) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (34) expanding domestic violence restraining orders to include dating partners; (45) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (56) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (67) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

RECOMMENDATION B:

Resolution 002 be adopted as amended.

RESOLVED, That our AMA work with relevant stakeholders to develop state-specific training programs for medical professionals on how to use Extreme Risk Protection Order/Red Flag Laws; and be it further...
RESOLVED, That our AMA will work with relevant stakeholders to update medical curricula with training surrounding how to approach conversations about Extreme Risk Protection Order/Red Flag laws with patients and families; and be it further

RESOLVED, That our AMA supports amending policy “Firearms and High-Risk Individuals H-145.972” by addition to read:

**Firearms and High-Risk Individuals H-145.972**

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, medical professionals, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

VRC testimony was overwhelmingly supportive. The Reference Committee agrees with testimony from the American Psychiatric Association (APA) that “medical professionals” in the third resolve clause should be removed due to liability and logistical issues with law enforcement involvement. The Reference Committee recommends an amendment to remove the concern of liability and the expansion to medical professionals. Your Reference Committee recommends Resolution 002 be adopted as amended.

(12) RESOLUTION 003 - PURCHASED AND REFERRED CARE EXPANSION

**RECOMMENDATION A:**

The first Resolve of Resolution 003 be amended by addition and deletion:

RESOLVED, Our AMA will advocate to Congress to fully fund 1) increase funding to the Indian Health Service Purchased/Referred Care Program to enable the program to fully meet the healthcare needs of AI/AN patients and 2) expand eligibility to patients served by Urban Indian Health Programs

**RECOMMENDATION B:**
**Resolution 003 be adopted as amended.**

RESOLVED, our AMA will advocate fully funding the Indian Health Service Purchased/Referred Care Program and expanding eligibility to patients served by Urban Indian Health Programs; be it further

RESOLVED, our AMA encourages nonprofit hospitals to allocate community benefit dollars to increase access to specialty care for patients referred from Indian Health Service, Tribal, and Urban Indian Health Programs.

VRC testimony was supportive with amendments. The Reference Committee agrees with testimony that “fully fund” in the first resolve clause is open to interpretation and needs clarifying language without compromising the intent to fully meet the needs of the AI/AN population. Your Reference Committee recommends resolution 003 be adopted as amended.

(13) **RESOLUTION 011 - TRIBAL HEALTH PROGRAM ELECTRONIC HEALTH RECORD MODERNIZATION**

**RECOMMENDATION A:**

The second Resolve of Resolution 011 be amended by deletion:

RESOLVED, That our AMA encourages per capita funding parity for electronic health record operations between the Indian Health Service and Veterans’ Health Administration.

**RECOMMENDATION B:**

Resolution 011 be adopted as amended.

RESOLVED, That our AMA supports adequate funding for electronic health record modernization and maintenance costs for Tribal and Urban Indian Health Programs with active self-governance compacts and contracts with the Indian Health Service; and be it finally

RESOLVED, That our AMA encourages per capita funding parity for electronic health record operations between the Indian Health Service and Veterans’ Health Administration.

VRC testimony was supportive of the resolution with an amendment to delete the second resolve clause to which the authors testified in favor. VRC testimony supported amending existing policy but authors noted it was not appropriate in the context of negotiating with self-governing authorities and contracts rather than upkeep of federal facilities. The
Reference Committee agrees with VRC testimony that the second resolve clause does not have enough evidence in regard to per capita funding parity to support the ask and may limit advocacy going forward. Your Reference Committee recommends Resolution 011 be adopted as amended.

(14) RESOLUTION 013 - RECONSIDERATION OF THE BIRTHDAY RULE

RECOMMENDATION A:

The first Resolve of Resolution 013 be amended by addition and deletion:

RESOLVED, Our AMA will support evidence-based legislation that support a parent’s, or guardian’s primary parent when relevant, choice of their dependent’s health insurance plan under the event of multiple insurers; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 013 be amended by addition:

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

Delay in Payments Due to Disputes in Coordination of Benefits, H-190.969

Our AMA:

(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;

(2) includes the "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;

(3) urges state medical associations to advocate for the inclusion of the "employer first rule", and "birthday rule" as a last resort only after parents/guardians have been allowed a choice of insurer and have failed to choose, in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;
(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;

(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;

(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and

(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.

RECOMMENDATION C:

Resolution 013 be adopted as amended.

RESOLVED, Our AMA will support evidence-based legislation that support a parent’s, or primary parent when relevant, choice of their dependent’s health insurance plan under the event of multiple insurers; and be it further

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

Delay in Payments Due to Disputes in Coordination of Benefits, H-190.969
Our AMA:

(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries’ claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;

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

VRC testimony was supportive of the resolution. The AMA has existing policy on this subject and the update to said policy aligns insurance policy selection for newborns with best practices. The Reference Committee agrees with testimony to broaden terms used to describe the legal family structure. Your Reference Committee recommends Resolution 013 be adopted as amended.

(15) RESOLUTION 014 - INDIAN HEALTH SERVICE GRADUATE MEDICAL EDUCATION

RECOMMENDATION A:
The first Resolve of Resolution 014 be amended by addition and deletion:
Resolved, That our AMA advocate for the establishment of an Office of Academic Affiliations with the that Congress establish an Indian Health Service (IHS) equivalent to the Veterans Health Administration Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs; and be it further
RECOMMENDATION B:

The second Resolve of Resolution 014 be amended by addition and deletion:

Resolved, our AMA supports the development of novel dedicated graduate medical education (GME) funding streams for full-time positions at Indian Health Service, Tribal, and Urban Indian Health Programs.

RECOMMENDATION C:

Resolution 014 be adopted as amended.

RESOLVED, That our AMA advocate for the establishment of an Indian Health Service (IHS) equivalent to the Veterans Health Administration Office of Academic Affiliations; and be it further

RESOLVED, That our AMA supports the development of dedicated graduate medical education (GME) funding streams at Indian Health Service, Tribal, and Urban Indian Health Programs.

VRC testimony was supportive of the resolution with amendments. The Reference Committee agrees with testimony to amend the first resolve to align more clearly with the whereas clauses. We suggest the second resolve clause be amended so as to be clear that these funds do not draw away from existing GME positions and are for the purpose of full-time residencies rather than electives or away rotations as are currently available. Your Reference Committee recommends that Resolution 014 be adopted as amended.

(16) RESOLUTION 018 - ESTROGEN AS A RISK FACTOR FOR STROKE IN PATIENTS WITH MIGRAINE WITH AURA

RECOMMENDATION A:

Policy H-75.990 be reaffirmed in lieu of the first Resolve of Resolution 018.

RECOMMENDATION B:

The second Resolve of Resolution 018 be amended by addition and deletion:

RESOLVED that our AMA work with relevant stakeholders to advocate for increased resources to allow for appropriate education and assessment, when indicated, of migraine and migraine with aura consistent with current
diagnostic guidelines in medical practice sites inclusive of but not limited
to primary care, obstetrics and gynecology, endocrinology, neurology, and
cardiology clinics.

RECOMMENDATION C:

Resolution 018 be adopted as amended with a title change.

Title: “Providing Evidence-based Care to Patients with Migraine and
Migraine with Aura”

Resolved that our AMA support further research regarding the role of estrogen as a risk
factor for stroke and cardiovascular events at the dosages and routes found in combined
oral contraceptive pills, vaginal rings, transdermal patches, and hormone replacement
therapy in individuals with migraine and migraine with aura; and be it further

Resolved that our AMA work with relevant stakeholders to advocate for increased
education and assessment, when indicated, of migraine with aura consistent with current
diagnostic guidelines in medical practice sites inclusive of but not limited to primary care,
obstetrics and gynecology, neurology, and cardiology clinics.

VRC testimony was mixed. The Reference Committee agrees with the House
Coordination Committee’s decision to place the first resolve clause of Resolution 018 on
the reaffirmation consent calendar. We agree with testimony to amend the second
thereby clarifying that although AMA does not set practice guidelines, we can work with
relevant stakeholders to do so. Your Reference Committee recommends Resolution 018
be adopted as amended.

Development and Approval of New Contraceptives
H-75.990

Our AMA: (1) supports efforts to increase public funding of contraception and
fertility research; (2) 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; and (3) 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.

(17) RESOLUTION 028 - INCLUDING GENDER INCLUSIVE LANGUAGE IN
MENSTRUAL HEALTHCARE

RECOMMENDATION A:
The first Resolve of Resolution 028 be amended by addition and deletion:

RESOLVED that our AMA-MSS supports gender-neutral language with regards to reproductive rights including but not limited to menstrual products in medical education, clinical training, and clinical practice both practice and in training; to ensure the needs of all individuals who menstruate are met; and be it further,

RECOMMENDATION B:

The second Resolve of Resolution 028 be amended by deletion:

RESOLVED, That our AMA amend current policy that includes de-gendered language to include transgender and non-binary individuals who have a uterus and can menstruate.

Considering Menstrual Feminine Hygiene Products as Medical Necessities, H-525.974

Our AMA: (1) encourages the Internal Revenue Service to classify feminine hygiene products menstrual products as medical necessities; (2) will work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products menstrual products in state and local prisons and correctional institutions to ensure incarcerated women that menstrual products be provided free of charge, the appropriate type and quantity of feminine hygiene products menstrual products including tampons for their needs; and (3) encourages the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers.

RECOMMENDATION C:

Resolution 028 be amended by addition of a new Resolve:

RESOLVED, That our AMA-MSS supports training for healthcare providers that includes de-gendered language and inclusivity for various period products to better understand the needs of all persons who menstruate; and be it further

RECOMMANDATION D:
The second Resolve of Resolution 028 be amended by addition of a new Resolve:

RESOLVED, That our AMA-MSS administratively amends existing MSS policy which includes mention of “feminine hygiene products,” namely 160.032MSS, 525.008MSS, 525.009MSS, and 525.015MSS, to replace the phrase “feminine hygiene” with “menstrual.”

RECOMMENDATION E:

Resolution 028 be adopted as amended.

RESOLVED, That our AMA supports gender-neutral language with regards to menstrual products in both practice and in training to ensure the needs of all individuals who menstruate are met; and be it further

RESOLVED, That our AMA amend current policy that includes de-gendered language to include transgender and non-binary individuals who have a uterus and can menstruate.

Considering Menstrual Feminine Hygiene Products as Medical Necessities, H-525.974

Our AMA: (1) encourages the Internal Revenue Service to classify feminine hygiene products menstrual products as medical necessities; (2) will work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products menstrual products in state and local prisons and correctional institutions to ensure incarcerated women that menstrual products be provided free of charge, the appropriate type and quantity of feminine hygiene products menstrual products including tampons for their needs; and (3) encourages the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers.

VRC testimony was supportive. We discussed concerns of reaffirmation given pending transmittal number 53, which supports the use of gender-neutral language, and ultimately recommend amending the resolution to make the policy internal to the MSS. The presence of internal policy related to gender neutral language in reproductive health will allow our Caucus to advocate for the asks of the author when transmittal 53 is brought to the HOD. The Reference Committee agrees with the authorship team’s amendment to the first resolve and the addition of a new second resolve clause. We recommend the addition of a third resolve clause to improve standardization of “menstrual products” throughout MSS policy. Your Reference Committee recommends Resolution 028 be adopted as amended.
(18) RESOLUTION 033 - THE HEALTH CARE RELATED EFFECTS OF RECENT CHANGES TO THE US MEXICO BORDER

RECOMMENDATION A:

Resolution 033 be amended by addition and deletion:

RESOLVED, Our AMA recognizes the health related effects and humanitarian consequences of increasing the U.S. Mexico border barrier height on immigrant populations recent changes to the barriers between the US and Mexico on immigrant populations and the resulting increased burden to the US healthcare system.

RECOMMENDATION B:

Resolution 033 be adopted as amended.

VRC testimony was supportive with amendments. The Reference Committee agrees with testimony to expand on the referenced “recent changes to the barriers” as there whereas clauses specifically refer to the increased height of the barrier wall and the health effects of crossing or falling from said barrier, as well as accounting for future modifications to the barrier wall. We agree with testimony that this resolution should be removed from the House Coordination Committee’s reaffirmation consent calendar. Your Reference Committee recommends Resolution 033 be adopted as amended.

(19) RESOLUTION 034 - CONSERVATORSHIP AND GUARDIANSHIP REFORM

RECOMMENDATION A:

The second Resolve of Resolution 034 be amended by addition:

RESOLVED, That our AMA study the impact of less restrictive alternatives to guardianships and conservatorships including supported decision making on medical decision making, health outcomes, and quality of life.

RECOMMENDATION B:

Resolution 034 be adopted as amended.
RESOLVED, That our AMA support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse; and be it further

RESOLVED, That our AMA study the impact of supported decision making on medical decision making, health outcomes, and quality of life.

VRC testimony was supportive with amendments. The Reference Committee agrees with testimony that the first resolve clause is well-written. We agree with testimony that the second resolve clause should be expanded to include the study of alternatives to guardianship and conservatorship. Your Reference Committee recommends Resolution 034 be adopted as amended.

(20) RESOLUTION 035 - ADVOCATING FOR THE REGULATION OF WASTE PRODUCTS IN INDUSTRIALIZED FARMING

RECOMMENDATION A:

The first Resolve of Resolution 035 be amended by addition and deletion:

RESOLVED, That our AMA recognizes Concentrated Animal Feeding Operations (CAFOs) as a threat to public health hazard; and be it further

RECOMMENDATION B:

The third Resolve of Resolution 035 be amended by deletion:

RESOLVED, That our AMA encourages the EPA and appropriate stakeholders to allocate funding toward the development and increased utilization of emerging technology in agricultural waste treatment.

RECOMMENDATION C:

Resolution 035 be adopted as amended.

RESOLVED, That our AMA recognizes Concentrated Animal Feeding Operations as a threat to public health; and be it further

RESOLVED, That our AMA encourage the EPA and appropriate stakeholders to remove the regulatory exemptions for CAFOs under EPCRA and CERCLA and tighten restrictions on pollution from CAFOs; and be it further
RESOLVED, That our AMA encourages the EPA and appropriate stakeholders to allocate funding toward the development and increased utilization of emerging technology in agricultural waste treatment.

VRC testimony was limited and mixed. The Reference Committee recommends amending the first resolve clause to make language consistent with those used for similar environmental hazards in other AMA policies. We agree with testimony that the third resolve clause should be struck because the ask is broad and unsupported by the whereas clauses, which do not reference emerging technologies. Your Reference Committee recommends Resolution 035 be adopted as amended.

(21) RESOLUTION 036 - EMERGENCY ANTI-EPILEPTIC INTERVENTIONS

RECOMMENDATION A:

The second Resolve of Resolution 036 be amended by addition and deletion:

RESOLVED, That our AMA encourage physicians to educate patients and families affected by epilepsy on status epilepticus and work with patients and families to develop an individualized action plan for possible status epilepticus, the which may include distribution of home pharmacotherapy for status epilepticus, in accordance with the physician’s best clinical judgment, by urging physicians to work with patients to develop an emergency anti-epileptic plan.

RECOMMENDATION B:

Resolution 036 be adopted as amended with a title change.

Title: “Emergency Anti-Seizure Interventions”

RESOLVED, That our AMA support efforts in the recognition of status epilepticus and bystander intervention trainings; and be it further

RESOLVED, That our AMA encourage the distribution of home pharmacotherapy for status epilepticus by urging physicians to work with patients to develop an emergency anti-epileptic plan.

VRC testimony was supportive with amendments. The Reference Committee agrees with testimony that a title change clarifies the language used for medications to manage seizures. We agree with testimony that the second resolve clause should be amended to consider different populations, modalities of rescue medications, and patient education.
on short-acting PRN benzos. Your Reference Committee recommends Resolution 036 be adopted as amended with a title change.

(22) RESOLUTION 038 - STUDYING POPULATION-BASED PAYMENT POLICY DISPARITIES

RECOMMENDATION A:

The first Resolve of Resolution 038 be amended by addition and deletion:

RESOLVED, That our AMA study opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services predominantly provided to underserved populations to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas.

RECOMMENDATION B:

The second Resolve of Resolution 038 be amended by addition and deletion:

RESOLVED, That our AMA study the effects of differences in relative factors such as valuation and reimbursement rates on subsequent trainee interest, physician choice of specialty, degree of institutional support, adequacy of workforce shortages, burnout, and attrition and income, especially in specialties and practice settings that primarily care for underserved populations; and be it further

RECOMMENDATION C:

Resolution 038 be adopted as amended.

RESOLVED, That our AMA study opportunities to incentivize health services predominantly provided to underserved populations such as women, LGBTQ+ patients, children, elder patients, patients with disabilities; and be it further

RESOLVED, That our AMA study the effects of differences in relative valuation and reimbursement on subsequent trainee interest, institutional support, adequacy of workforce, attrition, burnout, and income, especially in specialties that primarily care for underserved populations.
VRC testimony was supportive of the resolution with amendments. The Reference Committee agrees with VRC testimony that this resolution is not reaffirmation and should be removed from the House Coordination Committee’s reaffirmation consent calendar. We agree with VRC testimony that this resolution focuses on those financial factors, such as relative valuation and reimbursement rates, which affect incentives influencing the physician workforce, and ultimately contribute to shortages of physicians providing services which are most utilized by underserved populations. The resolution was mended to clarify the distinct ask from existing policy. Your Reference Committee recommends Resolution 038 be adopted as amended.

(23) RESOLUTION 039 - SCHOOL-TO-PRISON PIPELINE

RECOMMENDATION A:

The first Resolve of Resolution 039 be amended by addition and deletion:

Student-Centered Approaches for Reforming School Disciplinary Policies H-60.900

Our AMA supports: (1) evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior; and (2) the consultation with school-based mental health professionals in the student discipline process; and (3) efforts to address physical and mental trauma experienced by children in K-12 education by reducing disproportionate punitive disciplinary actions in K-12 education and the involvement of law enforcement in student discipline; (4) ensuring that any law enforcement presence in K-12 schools focuses on maintaining student and staff safety and not on disciplining students; (5) transitions to restorative approaches including but not limited to that individually address students’ medical, social, and educational needs; and; (6) efforts to prevent interactions between students and law enforcement as much as possible to avoid risk of incarceration.

RECOMMENDATION B:

Resolution 039 be adopted as amended.

RESOLVED, That our AMA amend by addition and deletion as follows:

Student-Centered Approaches for Reforming School Disciplinary Policies H-60.900

Our AMA supports: (1) evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior; and (2) the consultation with school-based mental health professionals in the student discipline process; and (3) efforts to address physical and mental trauma experienced by children in K-12 education by reducing disproportionate punitive disciplinary actions in K-12 education and the involvement of law enforcement in student discipline; (4) ensuring that any law enforcement presence in K-12 schools focuses on maintaining student and staff safety and not on disciplining students; (5) transitions to restorative approaches including but not limited to that individually address students’ medical, social, and educational needs; and; (6) efforts to prevent interactions between students and law enforcement as much as possible to avoid risk of incarceration.
discipline process; (3) efforts to address physical and mental trauma experienced by children in K-12 education by reducing punitive disciplinary actions in K-12 education and the involvement of law enforcement in student discipline; (4) ensuring that any law enforcement presence in K-12 schools focuses on maintaining student and staff safety and not on disciplining students; (5) transitions to restorative approaches that individually address students’ medical, social, and educational needs, and; (6) efforts to prevent interactions between students and law enforcement as much as possible to avoid risk of incarceration.

VRC testimony was supportive with amendments. The Reference Committee agrees with testimony to amend the resolution due to overlap with existing policy, particularly H-60.902 that emphasizes practices involving law enforcement officers in school which create effective learning environments for children, and with other resolve clauses. Your Reference Committee recommends an amendment to clause three to address concerns with the broad term “punitive disciplinary actions.” The Reference Committee discussed at length the implications and impact of clause six and agreed that it was neither feasible nor actionable as currently written. Your Reference Committee recommends Resolution 039 be adopted as amended.

(24) RESOLUTION 044 - ENVIRONMENTAL HEALTH EQUITY IN FEDERALLY SUBSIDIZED HOUSING

RECOMMENDATION A:

Resolution 044 be amended by addition of a new Resolve:

RESOLVED, That our AMA acknowledge the potential adverse health impacts of living in close proximity to a Superfund site; and be it further

RECOMMENDATION B:

The first Resolve of Resolution 044 be amended by addition and deletion:

RESOLVED, That our AMA advocate for federally mandated disclosure of Superfund site proximity and potential threat assessments to those purchasing, leasing, or currently residing in federally subsidized housing in close proximity to Superfund sites.; and be it further

RECOMMENDATION C:

The second Resolve of Resolution 044 be amended by deletion:
RESOLVED, That our AMA advocates for the expansion of Medicare and Medicaid to provide, free of cost, environmental health-related care including but not limited to blood testing, prenatal screening, intellectual delay screenings, and prescriptions for heavy metal chelating drugs; and be it further

RECOMMENDATION D:

The third Resolve of Resolution 044 be amended by deletion:

RESOLVED, That our AMA support efforts to expand Medicare and Medicaid eligibility to those residing in housing in proximity to Superfund sites; and be it further

RECOMMENDATION E:

The fourth Resolve of Resolution 044 be amended by addition and deletion:

RESOLVED, That the AMA advocate support for policies that efforts of public agencies to study the safety of proposed public housing expansions with respect to pollutant exposure and to expand the construction of new federally public and publicly subsidized housing properties on lands without demonstrated unsafe levels of hazardous pollutants, proven to be free of known hazardous pollutants including but not limited to lead, hexavalent chromium, radium, perfluorinated chemicals (PFCs), and polychlorinated biphenyl chemicals (PCBs); and be it further

RECOMMENDATION F:

The fifth Resolve of Resolution 044 be amended by deletion:

RESOLVED, That our AMA advocate for existing federally subsidized housing properties to be vacated at the same rate as construction of new federally subsidized housing properties to mitigate damage to current residents.

RECOMMENDATION G:

Resolution 044 be adopted as amended.

RESOLVED, That our AMA advocate for federally mandated disclosure of Superfund site proximity and potential threat assessments to those purchasing, leasing, or currently residing in federally subsidized housing; and be it further
RESOLVED, That our AMA advocates for the expansion of Medicare and Medicaid to provide, free of cost, environmental health-related care including but not limited to blood testing, prenatal screening, intellectual delay screenings, and prescriptions for heavy metal chelating drugs; and be it further

RESOLVED, That our AMA support efforts to expand Medicare and Medicaid eligibility to those residing in housing in proximity to Superfund sites; and be it further

RESOLVED, That the AMA advocate for policies that expand the construction of new federally subsidized housing properties on land proven to be free of known hazardous pollutants including but not limited to lead, hexavalent chromium, radium, perfluorinated chemicals (PFCs), and polychlorinated biphenyl chemicals (PCBs); and be it further

RESOLVED, That our AMA advocate for existing federally subsidized housing properties to be vacated at the same rate as construction of new federally subsidized housing properties to mitigate damage to current residents.

VRC testimony was mixed. The Reference Committee agrees with testimony to amend the first resolve clause to open the requirement for disclosure to all housing. We agree with testimony that the second and third resolve clauses should be deleted because expansion of public insurance is not supported by evidence presented in the resolution, nor is sufficient attention given to the logistical challenges of the proposed expanded eligibility criteria. Your Reference Committee recommends an amendment to resolve clause four based on testimony that the language is too prescriptive, though the testimony on the VRC was generally supportive of the aims of this clause. Additionally, we agree with recommendations to strike the fifth resolve clause because the specificity of the ask makes the clause infeasible. The Reference Committee recommends the addition of a new resolve clause one to connect the resolution to the evidence from the whereas clauses. Your Reference Committee recommends Resolution 044 be adopted as amended.

(25) RESOLUTION 046 - ENCOURAGING INCREASED ACCESSIBILITY AND UTILIZATION OF OCCUPATIONAL PULMONARY LUNG DISEASE SCREENINGS

RECOMMENDATION A:

The first Resolve of Resolution 046 be amended by deletion:

RESOLVED, That our AMA recognizes inequities in occupational health screenings for pulmonary lung disease and supports efforts to increase access to these screenings in marginalized communities; and be it further
RECOMMENDATION B:
The second Resolve of Resolution 046 be amended by addition and
deletion:

RESOLVED, That our AMA amend Policy 365.988 “Integration of
Occupational Medicine, Environmental Health, and Injury Prevention
Programs into Public Health Agencies” by insertion as follows:

Integration of Occupational Medicine, Environmental Health, and Injury
Prevention Programs into Public Health Agencies, H-365.988
Our AMA supports: (1) supports the integration of occupational health and
environmental health and injury prevention programs within existing health
departments at the state and local level; (2) supports taking a leadership
role in assisting state medical societies in implementation of such
programs; and (3) supports working with federal agencies to ensure that
"health" is the primary determinant in establishing environmental and
occupational health policy; (4) recognizes barriers to accessibility and
utilization of such programs; (5) recognizes inequities in occupational
health screenings for pulmonary lung disease and supports efforts to
increase accessibility of these screenings in marginalized communities;
and (6) encourages utilization of accessible screenings, such as those
used in the NIOSH Coal Workers Health Surveillance Program, for other at
risk occupational groups and utilization of these free screenings.

RECOMMENDATION C:

Resolution 046 be adopted as amended.

RESOLVED, That our AMA recognizes inequities in occupational health screenings for
pulmonary lung disease and supports efforts to increase access to these screenings in
marginalized communities; and be it further

RESOLVED, That our AMA amend Policy 365.988 “Integration of Occupational
Medicine, Environmental Health, and Injury Prevention Programs into Public Health
Agencies” by insertion as follows:

Integration of Occupational Medicine, Environmental Health, and Injury
Prevention Programs into Public Health Agencies, H-365.988
Our AMA supports: (1) the integration of occupational health and environmental
health and injury prevention programs within existing health departments at the
state and local level; (2) taking a leadership role in assisting state medical
societies in implementation of such programs; and (3) working with federal
agencies to ensure that "health" is the primary determinant in establishing
environmental and occupational health policy; (4) recognize barriers to accessibility and utilization of such programs; (5) encourages utilization of accessible screenings, such as those used in the NIOSH Coal Workers Health Surveillance Program, for other at risk occupational groups and utilization of these free screenings.

VRC testimony was supportive of the resolution with amendments. The Reference Committee agreed with VRC testimony that the first resolve clause should be removed and added into an amendment to existing policy H-365.988. In particular, there was a concern that advocating for access amounted to promoting insurance coverage which comes in conflict with AMA opposition to benefit mandates (H-185.964). The term accessibility referring to ease of receiving screening in various occupational health settings was substituted. Grammatical amendments were made to make the entire policy’s tense consistent. Your Reference Committee recommend Resolution 046 be adopted as amended.

(26) RESOLUTION 047 - INCREASING DIVERSITY IN STEM CELL BIOBANKS AND DISEASE MODELS

RECOMMENDATION A:

The first Resolve of Resolution 047 be amended by addition and deletion:

RESOLVED, Our AMA encourages research institutions and stakeholders to (1) re-evaluate inclusion and exclusion criteria to increase minority participation in stem cell research, recruitment strategies and materials to encourage participation by underrepresented populations, and (2) consider repeating prior experiments with cell lines from different populations; and it be further

RECOMMENDATION B:

The third Resolve of Resolution 047 be amended by addition and deletion:

RESOLVED, Our AMA strongly encourages institutional biobanks to collect racially and ethnically diverse induced pluripotent stem cells samples and expand their accessibility such that future induced pluripotent stem cell disease models can better represent the population.

RECOMMENDATION C:

Resolution 047 be adopted as amended.
RESOLVED, Our AMA encourages research institutions and stakeholders to (1) re-evaluate inclusion and exclusion criteria to increase minority participation in stem cell research, and (2) consider repeating prior experiments with cell lines from different populations; and be it further

RESOLVED, Our AMA amends Policy H-460.915, “Cloning and Stem Cell Research,”

Cloning and Stem Cell Research, H-460.915

Our AMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood stem cells); (2) urges the use of stem cell lines from different ethnicities in disease models; (3) supports the use of somatic cell nuclear transfer technology in biomedical research (therapeutic cloning); (4) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); (5) encourages strong public support of federal funding for research involving human pluripotent stem cells and (6) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology; and be it further

RESOLVED, Our AMA strongly encourages institutional biobanks to collect racially and ethnically diverse induced pluripotent stem cells and expand their accessibility such that future disease models can better represent the population.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the first resolve clause should be amended to address actionable barriers to implementation, especially as the evidence in the whereas clauses cite a lack of reporting relevant demographic data, and not overly restrictive inclusion/exclusion criteria, pers se. Additionally, establishing a directive to have researchers repeat studies would carry a cost and effort burden on investigators that may be outside of the purview of the AMA. Your Reference Committee recommends the third resolved clause be amended to align with the evidence from the whereas clauses. Your Reference Committee recommends Resolution 047 be adopted as amended.

(27) RESOLUTION 051 - PROVIDING MODEST ATTIRE OPTIONS AT HOSPITALS FOR PATIENTS AND EMPLOYEES

RECOMMENDATION A:

The first Resolve of Resolution 051 be amended by addition and deletion:

RESOLVED, That our AMA support the provision of safe, modest culturally and religiously sensitive operating room scrubs and hospital attire options for both patients and employees.
RECOMMENDATION B:

Resolution 051 be adopted as amended with a title change.

Title: “Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees”

RESOLVED, That our AMA support the provision of safe, modest operating room scrubs and hospital attire options for both patients and employees.

VRC testimony was supportive of the resolution with an amendment to the first resolve clause. The Reference Committee agrees with VRC testimony that amending the resolution to clarify “modest” attire is beneficial. Defining attire as modest can be subjective, carrying a greater chance of misinterpretation. As such, we believe the amended language from modest to culturally and religiously sensitive clarifies the authors’ intent. We have amended the title to reflect this clarification of language. We also discussed that scrubs are not considered PPE and thus, are not covered under existing policy H-440.810. Your Reference Committee recommends Resolution 051 be adopted as amended.

(28) RESOLUTION 058 - ARTIFICIAL INTELLIGENCE-INTEGRATED SOFTWARE FOR IMAGE MANIPULATION DETECTION

RECOMMENDATION A:

The first Resolve of Resolution 058 be amended by addition and deletion:

RESOLVED, That our AMA work with relevant stakeholders to support the creation of a nationally collaborative database of manipulated images from retracted publications to provide a test bank for researchers developing artificial intelligence-integrated automated image screening tools.

RECOMMENDATION B:

Resolution 058 be adopted as amended.

RESOLVED, That our AMA work with relevant stakeholders to promote the creation of a nationally collaborative database of images from retracted publications to provide a test bank for researchers developing automated image screening tools.
VRC testimony was mixed. The Reference Committee agrees with testimony that the resolution is too prescriptive as written and should be amended to be more feasible, and to reflect the title and whereas clauses regarding image manipulation and to better align with its title and intention. Your Reference Committee recommends Resolution 058 be adopted as amended.

RECOMMENDATION A:

The first Resolve of Resolution 060 be amended by addition:

RESOLVED, That our AMA-MSS define “Personal Finance Education” as education on topics including, but not limited to: (1) Practice models and contract negotiations; (2) Risk management and insurance; (3) Financial principles; (4) Savings and Investments; (5) Debt Management; (6) Retirement Planning; (7) Estate Planning; (8) Budgeting; and (9) Use of Credit scores and Credit Cards; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 060 be amended by deletion:

RESOLVED, That Our AMA develop high-quality self-directed resources, such as but not limited to CME courses or other online modules, on Personal Finance Education for medical students, medical schools, residents, and fellows to use; and be it further

RECOMMENDATION C:

The third Resolve of Resolution 060 be amended by addition and deletion:

RESOLVED, That our AMA-MSS will work with the LCME or other appropriate stakeholders to encourage medical schools to offer materials elective courses on Personal Finance Education.

RECOMMENDATION D:

Resolution 060 be adopted as amended.

RESOLVED, That our AMA define “Personal Finance Education” as education on topics including, but not limited to: (1) Practice models and contract negotiations; (2) Risk
management and insurance; (3) Financial principles; (4) Savings and Investments; (5) Debt Management; (6) Retirement Planning; (7) Estate Planning; (8) Budgeting; and (9) Use of Credit scores and Credit Cards; and be it further

RESOLVED, That Our AMA develop high-quality self-directed resources, such as but not limited to CME courses or other online modules, on Personal Finance Education for medical students, medical schools, residents, and fellows to use; and be it further

RESOLVED, That our AMA work with the LCME or other appropriate stakeholders to encourage medical schools to offer elective courses on Personal Finance Education.

VRC testimony was in support of the resolution with amendments. The Reference Committee notes that personal finance does not meet criteria for Continuing Medical Education and that it would take considerable cost and expertise for the AMA to develop a personal finance curriculum. Nor have the authors presented evidence that any available resources are insufficient. The Reference Committee recommends striking the second resolve. We also noted that the first resolve clause lacked an objective and was a definition more fitting for internal policy. Likewise, the lack of evidence for elective courses suggested that rather “materials” should be offered and that this can be advocated for as a section priority but on a case-by-case basis to medical schools in fitting with the suggestion that these be elective rather than added as a core component of medical school curricula as might require LCME input. Your Reference Committee recommends Resolution 060 be adopted as amended in light of the significant volume of supportive testimony on the item.

(30) RESOLUTION 062 - INCREASED INCLUSIVITY AND ADMISSION POLICIES CLARIFICATION FOR DACA MEDICAL SCHOOL AND RESIDENCY APPLICANTS

RECOMMENDATION A:

The first Resolve of Resolution 062 be amended by deletion:

RESOLVED, That our AMA provide support and encourage the Association of American Medical Colleges, individual medical schools, and residency programs to establish criteria that institutions must meet to declare themselves “Deferred Action for Childhood Arrivals-friendly”, including transparency in the admissions process and favorable financial-aid policies; and be it further

RECOMMENDATION B:
The second Resolve of Resolution 062 be amended by addition and deletion:

RESOLVED, That AMA encourages transparency from institutions in the medical school and residency application process for DACA recipients, including, when possible on a national level: by making certain data publicly accessible, in order to guide DACA applicants on their medical school and residency options including, at minimum: (1) the percentage number of Deferred Action for Childhood Arrivals applicants of total applicants, (2) the percentage number of accepted Deferred Action for Childhood Arrivals applicants of total accepted applicants, (3) the percentage number of matriculated Deferred Action for Childhood Arrivals students of total matriculated applicants, (4) financial aid and scholarship options available for Deferred Action for Childhood Arrivals applicants, (5) and the form of financial aid received, or payment provided, by accepted Deferred Action for Childhood Arrivals students.

RECOMMENDATION C:

Resolution 062 be adopted as amended.

RESOLVED, That our AMA provide support and encourage the Association of American Medical Colleges, individual medical schools, and residency programs to establish criteria that institutions must meet to declare themselves “Deferred Action for Childhood Arrivals-friendly”, including transparency in the admissions process and favorable financial aid policies; and be it further

RESOLVED, That AMA encourages transparency from institutions in the medical school and residency application process by making certain data publicly accessible, in order to guide DACA applicants on their medical school and residency options including, at minimum: (1) the number of Deferred Action for Childhood Arrivals applicants, (2) the number of accepted Deferred Action for Childhood Arrivals applicants, (3) the number of matriculated Deferred Action for Childhood Arrivals students, (4) financial aid options available for Deferred Action for Childhood Arrivals applicants, (5) and the form of financial aid received, or payment provided, by accepted Deferred Action for Childhood Arrivals students.

VRC testimony was supportive of amendments. The Reference Committee agrees with testimony that the first resolve clause is too specific and not feasible, and additionally notes that the AAMC does provide documentation and rating scale for DACA admission policies where available. The Reference Committee recommends amendments to the second resolve clause to protect privacy of data by changing “number” to “percentage-” to better protect the privacy of DACA students and applicants. The addition of Residents
and Fellows was not supported by the whereas clauses as noted by the Resident and
Fellows section and the Reference Committee recommends removing it. Your Reference
Committee recommends Resolution 062 be adopted as amended.

(31) RESOLUTION 064 - ENCOURAGING UNIVERSAL RETURN-TO-PLAY
PROTOCOLS FOR COMMON SPORT INJURIES IN COLLEGIATE AND
PROFESSIONAL ATHLETES

RECOMMENDATION A:

The second Resolve of Resolution 064 be amended by deletion:

RESOLVED, That our AMA encourage: (a) proper evaluation of mental
readiness and medical fitness of college and professional athletes before
allowing them to return to competitive play; (b) promotion of further
research into the most effective method and protocol for return-to-play at
the collegiate and professional level; (c) identification and abstention from
harmful practices in sports training of college and professional athletes.

RECOMMENDATION B:

Resolution 064 be adopted as amended.

RESOLVED, That our AMA encourages interested parties to: (a) establish a standard,
universal protocol for return-to-play recovery for collegiate and professional athletes; (b)
promote additional evidence-based studies on the effectiveness of a universal protocol for
evaluation and post-injury management course at collegiate and professional level; (c)
support national and state efforts to minimize the consequences of inadequate recovery
windows for collegiate and professional athletes; and be it further

RESOLVED, That our AMA encourage: (a) proper evaluation of mental readiness and
medical fitness of college and professional athletes before allowing them to return to
competitive play; (b) promotion of further research into the most effective method and
protocol for return-to-play at the collegiate and professional level; (c) identification and
abstention from harmful practices in sports training of college and professional athletes.

VRC testimony was supportive of the resolution with amendments. The Reference
Committee agrees with testimony that the second resolve clause will not add to the AMA’s
advocacy efforts and would recommend striking the clause. Your Reference Committee
recommends Resolution 064 be adopted as amended.

(32) RESOLUTION 068 - INCREASING REGULATION AND LABELING OF
FRAGRANCES IN PERSONAL CARE PRODUCTS, COSMETICS, AND DRUGS
RECOMMENDATION A:

The first Resolve of Resolution 068 be amended by addition and deletion:

RESOLVED, That our AMA work with relevant stakeholders such as the Food and Drug Administration and the U.S Consumer Product Safety Commission to support the appropriate labeling of fragrance-containing personal care products, cosmetics and drugs with warnings about possible allergic reactions or adverse events due to the fragrance, and advocates for increased categorization on the use of a of “fragrance free” designation; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 068 be amended by deletion:

RESOLVED, That our AMA advocate for relevant stakeholders to regulate personal care products containing any known fragrance compounds regardless of its disclosure on label, and give the appropriate agencies the ability to recall items containing harmful fragrances; and be it further

RECOMMENDATION C:

Resolution 068 be adopted as amended.

RESOLVED, That our AMA work with relevant stakeholders such as the Food and Drug Administration and the U.S Consumer Product Safety Commission to support the appropriate labeling of fragrance-containing personal care products and drugs with warnings about possible allergic reactions or adverse events due to the fragrance, and advocates for increased categorization on the use of a “fragrance free” designation; and be it further

RESOLVED, That our AMA advocate for relevant stakeholders to regulate personal care products containing any known fragrance compounds regardless of its disclosure on label, and give the appropriate agencies the ability to recall items containing harmful fragrances; and be it further

RESOLVED, That our AMA supports increased identification of hazardous chemicals in fragrance compounds, as well as research focused on fragrance sensitivity in order to remove these allergens from products applied to one’s body.

VRC testimony was mixed. The Reference Committee agrees with testimony that the first resolve clause should not list specific stakeholders as this can limit advocacy efforts. We
agree with testimony that the second resolve clause should be struck since it is not feasible to regulate products regardless of the disclosure on the label, especially as existing mechanisms allow for the legal enforcement of regulatory laws. H-440.855 already engages the FDA with the authority to recall harmful products, and contextual regulatory practices may lie with organizations beyond the AMA’s purview. Furthermore, the phrase “fragrance compound” is very broad and covers all substances with a component sufficiently volatile to be perceived by the olfactory system, which obscures who the relevant stakeholders are. Thus, Your Reference Committee recommends Resolution 068 be adopted as amended.

(33) RESOLUTION 079 - SUPPORT AND ADVOCACY FOR PERMANENT STANDARD TIME

RECOMMENDATION A:

The first Resolve of Resolution 079 be amended by addition and deletion:

RESOLVED, That our AMA-MSS amend Policy 440.109MSS, “Supporting Daylight Savings Time as the New, Permanent Standard Time” to read as follows:

Supporting and Advocacy for Daylight Savings Time as the New, Permanent Standard Time 440.109MSS: Our AMA-MSS will ask the AMA to: (1) recognizes the adverse health effects of biannual time changes and support the elimination of biannual time changing and (2) supports public health surveillance and research on the effects of adopting a year-round time, (3) recognizes the positive health effects of daylight savings permanent standard time and supports the adoption of permanent standard time (apt to longitude), (4) recognizes the detrimental health effects of permanent daylight savings time, and (5) advocates at the US federal level for the adoption of permanent standard time (apt to longitude) alongside relevant advocacy, state medical, and specialty medical societies support daylight savings time as the permanent standard time.

RECOMMENDATION B:

Resolution 079 be adopted as amended.

RESOLVED, That our AMA-MSS amend Policy 440.109MSS, “Supporting Daylight Savings Time as the New, Permanent Standard Time” to read as follows:

Supporting and Advocacy for Daylight Savings Time as the New, Permanent Standard Time 440.109MSS AMA-MSS will ask the AMA to: (1) recognize the adverse health effects of biannual time changes and support the elimination of
biannual time changing, and (2) recognize the positive health effects of daylight savings permanent standard time and support the adoption of permanent standard time (apt to longitude), (3) recognize the detrimental health effects of permanent daylight savings time, and (4) advocate at the US federal level for the adoption of permanent standard time (apt to longitude) alongside relevant advocacy, state medical, and specialty medical societies support daylight savings time as the permanent standard time.

VRC testimony was mixed. Reference committee notes multiple resolutions on this subject at the forthcoming HOD meeting as well, which may or may not be extracted from the Resolution Committee report for consideration. The Reference Committee agrees with testimony that this resolution should be amended to an internal ask, which will allow the MSS Caucus to appropriately represent the will of the caucus in the HOD if and when these resolutions submitted by other sections are debated on the floor. Your Reference Committee recommends Resolution 079 be adopted as amended.

(34) IOPTF REPORT - INTERNAL OPERATING PROCEDURES TASK FORCE REPORT

RECOMMENDATION A:

4.3. Qualifications. All members of the GC must be medical student members of the AMA at the time of their election and throughout their term. If graduating within 90 days prior to an Annual meeting, the officer will be permitted to serve until Annual Meeting completion (AMA Bylaw 7.3.2). Any medical student member of the AMA is eligible for a position on the MSS GC, except as prohibited by these IOPs or by the AMA Bylaws.

Rationale: VRC testimony was positive. We recommend clarity to the language in 4.3 for Governing Council (GC) election clarifications. We agree with testimony, and believe the addition of language that incorporates this clarity of term limits, while maintaining consistency in language and formatting already implemented across all of the IOPs strengthens the recommendation. Therefore, The Reference Committee recommends adoption as amended.

RECOMMENDATION B:

4.4.2.4. Organize MSS Assembly educational ancillary conference programming within over the structure duration of the AMA-MSS assembly meetings including annual, interim, and special meetings, as set forth by the MSS Speakers. This includes, but is not limited to, applications, selection, and speaker procurement.
Rationale: Testimony was mixed. The Reference Committee agrees with VRC that the language should be broadened to incorporate all times, but the specific use of the word “educational programming” instead of “conference programming” was to ensure the selection of plenary speakers stays within the speakers’ purview. Furthermore, we found that not specifying the MSS assembly could further open interpretation to include other meetings, like Physicians of the Future, should GC deem it appropriate. We believe this addition of language incorporates all of these aforementioned goals and stays within the Task Force’s original intent. Therefore, The Reference Committee recommends adoption as amended.

RECOMMENDATION C:

4.7.3 The intent of this Section is to limit combined service in all of these positions shall be limited to three (3) years total. An MSS member may serve on the same AMA Council for no more than two (2) years and may serve in the same GC position for no more than one (1) year. A person may not serve more than two (2) years in the same position, with the exception of GC positions (Section 4.5.2.).

Rationale: Based on VRC testimony, the Reference Committee discussed the only change should be clarity of language while maintaining consistency in the language and formatting already implemented across the IOPs. Therefore, The Reference Committee recommends adoption as amended.

RECOMMENDATION D:

7.3 The existence and purview of MSS Standing Committees and Task Forces may be determined by the GC or by action of the MSS Assembly.

Rationale: VRC testimony was positive, The Reference Committee believes this amendment is the will of the section and the task force agreed this was inline with their original intent. This addition clarifies the language and does not change the overall intent. Therefore, the Reference Committee recommends adoption as amended.

RECOMMENDATION E:

8.3.2. Elections for the Regional Delegates and Alternate Regional Delegates to the AMA HOD will be held within an appropriate window, as determined by GC, of the opening of the Interim Meeting of the MSS. Each Region must submit the name of its newly-elected Regional Delegates and Alternate Regional Delegates to the GC before the close of this window the Interim Meeting.
Rationale: The Reference Committee discussed the importance of flexibility surrounding elections for Regional Delegate and Alternate Regional Delegate elections. We recommend the amendment to change the language to a more flexible and less prescriptive window, and the task force was in agreement. Therefore, the Reference Committee recommends adoption as amended.

RECOMMENDATION F:

IOPTF Report be adopted as amended.

(35) CEQM WIM REPORT A - EXPANSION OF MEDICAID COVERAGE OF HPV SCREENING

RECOMMENDATION A:

The first Resolve of CEQM WIM Report A be amended by addition and deletion:

1) Your committees recommend amendment to existing policy Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971 in lieu of the first resolved clause:

Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971

1. Our AMA supports programs to screen all women individuals with relevant anatomy for breast and cervical cancer and that government funded programs be available for low income women individuals; the development of public information and educational programs with the goal of informing all women individuals with relevant anatomy about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income women individuals for breast and cervical cancer and to assure access to definitive treatment.

2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.

3. Our AMA encourages efforts by the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies in an effort to expand coverage for HPV testing including but not limited to in-office primary HPV testing.

RECOMMENDATION B:
The third Resolve of Resolution CEQM WIM Report A be amended by addition and deletion:

3) Your committees recommend amending by addition and deletion of the third resolved clause as follows:

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

RECOMMENDATION C:

CEQM WIM Report A be adopted as amended and the remainder of the report be filed.

Your Committee on Economics and Quality in Medicine and the Women in Medicine Committee recommend that the following recommendations be adopted and transmitted as separate resolutions to the AMA HOD and the remainder of this report is filed:

1) Your committees recommend amendment to existing policy Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971 in lieu of the first resolved clause:

Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971

1. Our AMA supports programs to screen all women individuals with relevant anatomy for breast and cervical cancer and that government funded programs be available for low income women individuals; the development of public information and educational programs with the goal of informing all women individuals with relevant anatomy about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income women individuals for breast and cervical cancer and to assure access to definitive treatment.

2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.

3. Our AMA encourages efforts by the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies in an effort to expand coverage for HPV testing including but not limited to primary HPV testing.

2) Your committees recommend amending by deletion of the second resolved clause as follows:
RESOLVED, That our AMA request the CMS to endorse national incentives for states to cover primary HPV testing by Medicaid, and be it further

3) Your committees recommend amending by addition and deletion of the third resolved clause as follows:

RESOLVED, That our AMA support further research by relevant stakeholders of HPV self-sampling in the U.S. to decrease health care disparities in cervical cancer screening.

VRC testimony was limited and supportive. The Reference Committee agrees with testimony that the report is well researched. We clarified the first resolve clause from primary HPV testing to in-office primary HPV testing as this was the method of primary HPV testing that was supported by evidence in the report. The Reference Committee agrees with testimony to amend the third resolve clause to clarify that research is needed to determine if HPV self-sampling can decrease health disparities in cervical cancer screening. Your Reference Committee recommends the recommendations of CEQM WIM Report A be adopted as amended.
RECOMMENDED FOR ADOPTION IN LIEU OF

(36) RESOLUTION 004- INCREASED EDUCATION AND ACCESS TO FERTILITY RESOURCES FOR U.S. MEDICAL STUDENTS
RESOLUTION 027- RECOGNITION OF THE DISPROPORTIONATE IMPACT OF INFERTILITY ON PHYSICIANS

RECOMMENDATION:

Resolution 004 be adopted as amended in lieu of Resolution 027:

RESOLVED, Our AMA will work with the Association of American Medical Colleges and other appropriate organizations to develop gender- and sexual minority-inclusive educational initiatives in medical education that raise awareness about (1) how peak child-bearing years correspond to the peak career-building years for many medical students and trainees; (2) the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age in medical students and trainees; (3) the high rate of infertility among medical students, trainees, and physicians; and (4) various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs; and be it further

RESOLVED, Our AMA will work with relevant organizations to investigate increase access to strategies mechanisms by which medical students can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage.

Resolution 004
RESOLVED, Our AMA will work with the Association of American Medical Colleges and other appropriate organizations to develop gender- and sexual minority-inclusive educational initiatives that raise awareness about (1) how peak child-bearing years correspond to the peak career-building years for many medical students and trainees; (2) the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age; (3) the high rate of infertility among physicians; and (4) various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs; and be it further

RESOLVED, Our AMA will work with relevant organizations to investigate mechanisms by which medical students can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage.

Resolution 027
RESOLVED, Our AMA recognizes the disproportionately increased rates of infertility among female physicians in comparison to their non-physician counterparts; and be it further,

RESOLVED, Our AMA recognizes the contribution of rigorous medical training on family planning among physicians, particularly physicians of childbearing age; and be it further,

RESOLVED, Our AMA supports further research into the factors contributing to infertility in physicians of all identities.

VRC testimony was in support of the spirit of both resolutions. The Reference Committee amended Resolution 004 to take into account the asks of Resolution 027. There was discussion of how the asks and spirit of both resolutions were similar and could be achieved as one resolution under Resolution 004. The third resolve clause of Resolution 027 asks to support research into factors contributing to infertility, which the reference committee deemed unnecessary in combination with Resolution 004, which asks to develop initiatives. In a similar sense, the amendment to Resolution 004 adds novelty in asking for increasing access to strategies instead of researching fertility preservation. The recommended amendments are novel because they seek to address the barrier of insurance coverage and incorporate the inclusion of medical students. It was noted that authors of Resolution 004 had worked with several groups within the AMA to clarify the intent of their asks. Your Reference Committee recommends Resolution 004 be adopted as amended in lieu of Resolution 027.

(37) RESOLUTION 012 - AMEND PREVENTING RESIDENT PHYSICIAN SUICIDE 310.054MSS TO INCLUDE ANNUAL OPT-OUT MENTAL HEALTH SCREENING FOR SUICIDE PREVENTION

RECOMMENDATION:

Substitute Resolution 012 be adopted in lieu of Resolution 012 with a title change:

Title: “Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents”

RESOLVED, that AMA policy H-295.858 be amended to read as follows:

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American
Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that:

1. include appropriate follow-up;
2. are outside the trainees' grading and evaluation pathways;
3. are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and

D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.

3. Our AMA encourages medical schools undergraduate and graduate medical programs to create mental health and substance abuse awareness and suicide prevention screening programs that would:

A. be available to all medical students, residents and fellows on an opt-out basis

B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

RESOLVED, that AMA policy 310.054MSS, “Preventing Resident Physician Suicide,” be amended to include annual opt-out mental health awareness screening as a means to address resident physician suicide as follows:
Preventing Resident Physician Suicide, 310.054MSS:
Preventing Resident Physician Suicide: AMA-MSS (1) urges residency programs to include consideration of resident mental health and average daily workload in deciding work hours for residents; (2) encourages residency programs to create mental health resources available for all physicians in order to create an supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities; and (4) encourages residency programs to include an annual opt-out mental health awareness screening for suicide prevention.

VRC testimony was supportive of the resolution. The Reference Committee agrees with testimony that this resolution will have more impact amending external policy H-295.858, which currently discusses encouragement of reporting rates of depression and suicide by medical schools on an opt-out basis, by the addition of residents and fellows. Your Reference Committee recommends Substitute Resolution 012 be adopted in lieu of Resolution 012.

(38) RESOLUTION 015 - PREVENTING HUMAN PAPILLOMAVIRUS (HPV) INFECTION AND HPV-ASSOCIATED CANCERS IN PEOPLE WHO ARE INCARCERATED

RECOMMENDATION:
Substitute Resolution 015 be adopted in lieu of Resolution 015:

RESOLVED, That our AMA-MSS amend policy 55.008MSS: Non-Cervical HPV Associated Cancer Prevention, by addition and deletion as follows:
Our AMA-MSS will ask our AMA to: (1) support legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV-associated cancers; and (2) amend policy H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, by addition and deletion as follows:

HPV VACCINE AND CERVICAL CANCER PREVENTION WORLDWIDE, H-440.872
1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening for those at risk; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, in all individuals regardless of sex, such as, but not limited to cervical cancer, head and neck cancer, anal cancer, and penile cancer, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by: (a) facilitating administration of HPV vaccinations in community-based settings including school settings, and (b) supporting state mandates for HPV vaccination for school attendance, and (c) facilitating administration of HPV vaccinations for incarcerated individuals.

RESOLVED, That our AMA amend Policy H-440.872, “HPV Vaccine and Cervical HPV-Associated Cancer Prevention Worldwide,” as follows:

HPV Vaccine and Cervical HPV-Associated Cancer Prevention Worldwide, H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.

2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low income and pre-sexually active populations, patients with low socioeconomic status, patients who are pre-sexually active, and patients who are incarcerated, and (c) recommends HPV
RESOLVED, That our AMA amend Policy H-430.986, “Health Care While Incarcerated,” as follows:

**Health Care While Incarcerated H-430.986**

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

2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.

7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.

8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.

9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon
release in order to accelerate access to comprehensive health care, including
mental health and substance use disorder services, and improve health outcomes
among this vulnerable patient population, as well as adequate funding; (b) the
collaboration of correctional health workers and community health care providers
for those transitioning from a correctional institution to the community; (c) the
provision of longitudinal care from state supported social workers, to perform
foundational check-ins that not only assess mental health but also develop lifestyle
plans with newly released people; and (d) collaboration with community-based
organizations and integrated models of care that support formerly incarcerated
people with regard to their health care, safety, and social determinant of health
needs, including employment, education, and housing.

11. Our AMA advocates for the continuation of federal funding for health insurance
benefits, including Medicaid, Medicare, and the Children’s Health Insurance
Program, for otherwise eligible individuals in pre-trial detention.

12. Our AMA advocates for the prohibition of the use of co-payments to access
healthcare services in correctional facilities.

13. Our AMA encourages collaboration with stakeholders to provide Human
papillomavirus (HPV) vaccination to people who are incarcerated for the
prevention of HPV-associated cancers.

VRC testimony was supportive with amendments. The Reference Committee agrees
with testimony that this resolution should be added to the pending MSS transmittal for
strategic purposes, however, we note the challenges with proposing amendments on the
floor or making an amendment that places a new version of the resolution in the tote, if
even possible. For this reason, we amend internal policy to allow caucus to guide
strategy as the language of Resolution 916 at this meeting may or may not be adopted
as reflected in our internal policy. Your Reference Committee recommends adopting
Substitute Resolution 015 in lieu of Resolution 015.

(39) RESOLUTION 017 - AMA OPPOSITION OF HEARTBEAT LAWS WHICH
INDICATE FIRST EVIDENCE OF EMBRYONIC CARDIAC ACTIVITY AS
PRESENCE OF FETAL HEARTBEAT

RESOLUTION 020 - LACK OF ACCESS TO ABORTION IS A THREAT TO
PUBLIC HEALTH

RECOMMENDATION:

Substitute Resolution 017 be adopted in lieu of Resolution 017 and
Resolution 020:
RESOLVED, That our AMA recognize that policies and legislation that limit access to abortion care are serious threats to public health; and be it further

RESOLVED, That our AMA will advocate for the explicit codification of protections for abortion care consistent with AMA policy into federal law; and be it further

RESOLVED, That our AMA oppose efforts to exclude provisions from spending bills which limit federal funds from being used for abortion care; and be it further

RESOLVED, That our AMA collaborate with relevant stakeholders including state medical societies to encourage amendments to existing state laws so that a “fetal heartbeat” is not inaccurately stated as synonymous with the first evidence of embryonic cardiac activity; and be it further

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

Resolution 017
RESOLVED, That the AMA oppose “heartbeat” laws and adopt the stance that the term “heartbeat” is not clinically or physiologically accurate until about 17 to 20 weeks when the four chambers of the heart are fully developed and can be detected via ultrasound; and it be further

RESOLVED, That the AMA lobby for amendments to state laws already in place which indicate that a “fetal heartbeat” is synonymous with the first evidence of embryonic cardiac activity.

Resolution 020
RESOLVED, Our AMA recognize that policies and legislation that limit access to abortion care are serious threats to public health; and be it further

RESOLVED, Our AMA recognize the Hyde Amendment as a racist policy and support efforts to repeal it; and be it further

RESOLVED, Our AMA will advocate for the explicit codification of protections for abortion care in all circumstances into federal law; and be it further

RESOLVED, Our AMA-MSS immediately forward this resolution to the House of Delegates.
VRC testimony was mixed. The Reference Committee recognizes the significant advocacy efforts but also barriers to current ongoing policies. After review of Board of Trustees Report 4 from this meeting, the Reference Committee recommends this substitute resolution. The first resolve clause was retained noting favorable testimony. VRC testimony was in support for the second resolve with a minor amendment to ensure consistency with AMA policy. The Reference Committee discussed if there were restrictive implications of advocating for explicit codification in this form, although we agreed that being consistent with AMA policy was the best avenue for this to go forward. While testimony recognized that H-5.998 has been interpreted as opposition to the Hyde amendment, the language therein is not entirely intuitive, and we propose substituting the third resolve to explicitly mention abortion in policy and not just title. We believe this new language makes the intent of the original resolution more actionable, rather than sole recognition of the Hyde Amendment as a racist policy. The fourth resolve clause was retained noting a suggestion that there be a recognition of the need to work with state societies to correct the language of state bills, but without referring to guidelines set by specialty societies. The final resolve clause is deemed necessary for this item to coincide with adoption and or recommendations for the relevant Board of Trustees Report 4 with an immediate forwarding clause. Your Reference Committee recommends Substitute Resolution 017 be adopted in lieu of Resolution 017 and Resolution 020.

(40) RESOLUTION 029 - NALOXONE ALTERNATIVES OR ADJUNCTS TO COMBAT SYNTHETIC OPIOID-INDUCED RESPIRATORY DEPRESSION

RECOMMENDATION:

Substitute Resolution 029 be adopted in lieu of Resolution 029:

RESOLVED, That our AMA amend D-95.987 by addition:

Prevention of Drug-Related Overdose D-95.987:

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; (b) support the development of adjuncts and alternatives to naloxone to combat synthetic opioid-induced respiratory depression and overdose; and (c) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.

RESOLVED, That our AMA work with relevant stakeholders to increase research into the development of naloxone adjuncts or alternatives for use in combating synthetic opioid-induced respiratory depression and overdose.

VRC testimony was supportive. The Reference Committee agrees with testimony that asks of this resolution are novel, meaningful, and are not reaffirmation of existing policy, and suggests that it be removed from the House Coordination Committee reaffirmation calendar. We agree with testimony that the asks of this resolution can be added to existing policy. Your Reference Committee recommends Substitute Resolution 029 be adopted in lieu of Resolution 029.

(41) RESOLUTION 032 - ADDRESSING THE IMPACT OF MEDICARE TRANSITION ON SPOUSAL HEALTHCARE

RECOMMENDATION:

Substitute Resolution 032 be adopted in lieu of Resolution 032:
RESOLVED, That our AMA-MSS supports efforts to improve spousal insurance coverage and access to healthcare for those affected by Medicare transition through existing efforts to cover the remaining uninsured under the Affordable Care Act.

RESOLVED, That our AMA work with appropriate stakeholders to improve spousal insurance coverage, access to healthcare, and healthcare utilization for those affected by Medicare transition; and be it further

RESOLVED, That our AMA encourages the Center for Medicare and Medicaid Services to explore the use of educational materials on health insurance coverage options for spouses of Medicare beneficiaries.

VRC testimony was mixed. The Reference Committee recommends adoption of a substitute resolution to encompass testimony that the resolution as written will not significantly change AMA’s advocacy efforts yet represents a compelling reason to continue to advocate for healthcare reform and can help guide our caucus in advocating for future policies. The Reference Committee recommends that the resolution be amended into internal policy so that the MSS can navigate further health reform efforts. Your Reference Committee recommends adoption of Substitute Resolution 032 in lieu of Resolution 032.

(42) RESOLUTION 055 - ADVOCATING FOR ACCESS TO SAFER SMOKING KITS AS PART OF HARM REDUCTION SERVICES

RECOMMENDATION:

Substitute Resolution 055 be adopted in lieu of Resolution 055:

RESOLVED, That our AMA-MSS support decriminalization of the possession, distribution, sale, and manufacture of drug paraphernalia for harm reduction purposes.

RESOLVED, Our AMA will produce an informational press release or infographic codifying its support for the distribution of safer smoking kits and detailing evidence in favor of their distribution; and be it further

RESOLVED, That our AMA amend Policy D-95.987 by addition to read as follows; and be it further

Prevention of Drug-Related Overdose, D-95.987

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

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

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use or distribution of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing, safer smoking kit materials, and injection drug preparation, use, and disposal supplies.

5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.

6. Our AMA will advocate for the decriminalization of distribution of “drug paraphernalia” for harm reduction purposes at both a state and federal level.

RESOLVED, That our AMA amend Policy H-95.989 by addition to read as follows; and be it further

**Drug Paraphernalia H-95.989**

The AMA opposes the manufacture, sale and use of drug paraphernalia except as it pertains to harm reduction materials such as but not limited to safer smoking kit materials, sterile syringes, and drug contamination testing materials.

RESOLVED, That our AMA amend Policy H-95.958 by addition to read as follows; and be it further

**Syringe and Needle Exchange Programs H-95.958**

Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state
legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes and other harm reduction materials including safer smoking kits.

RESOLVED, That our AMA collaborate with state and local medical societies and other relevant stakeholders to advocate for the distribution of safer smoking kits at all syringe exchange/harm reduction programs; and be it further

RESOLVED, That our AMA collaborate with state and local medical societies and other relevant stakeholders to allocate public funding for distribution of safer smoking kits and to eliminate barriers to the use of public funding for such distribution.

VRC testimony was mixed. Resolution 211 proposed by the Resident and Fellows Section at this 2022 Interim Meeting accounts for decriminalization of drug paraphernalia distribution through amendment to existing policy. Resolution 211 covers the asks of our resolution regarding distribution and possession. Your Reference Committee recommends amending the resolution into internal policy so that MSS can support the decriminalization of the sale and manufacture of drug paraphernalia for harm reduction purposes. Your Reference Committee recommends Substitute Resolution 055 be adopted in lieu of Resolution 055.

(43) RESOLUTION 061 - INCREASING ACCESS TO GENDER-AFFIRMING PROCEDURES THROUGH EXPANDED TRAINING AND EQUITABLE REIMBURSEMENT

RECOMMENDATION:

Substitute Resolution 061 be adopted in lieu of Resolution 061:

RESOLVED, That our AMA support expanded structured training for gender-affirming procedures by working with relevant stakeholders including but not limited to the Accreditation Council for Graduate Medical Education; and be it further

RESOLVED, That our AMA amend H-185.950, “Removing Financial Barriers to Care for Transgender Patients” by addition as follows:

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria and reimbursement of gender-affirming procedures by health insurance providers as recommended by the patient's physician.
RESOLVED, That our AMA-MSS Amend 65.012MSS Removing Barriers to Care for Transgender Patients by addition and deletion as follows:

65.012MSS Removing Barriers to Care for Transgender Patients:
AMA-MSS will ask the AMA to (1) support public and private health insurance coverage for treatment of gender dysphoria in adolescents and adults; and (2) oppose categorical exclusions of coverage for treatment of gender dysphoria in adolescents and adults when prescribed by a physician; and (3) support an “informed consent” model for coverage of transgender healthcare services that does not require evaluation by mental health professionals.

RESOLVED, Our AMA advocate for expanded structured training for gender-affirming procedures by working with relevant stakeholders including but not limited to the Accreditation Council for Graduate Medical Education; and be it further

RESOLVED, Our AMA advocate for equitable reimbursement of gender-affirming procedures by health insurance providers, including public and private insurers, which at minimum equates to the cost of performing these procedures.

VRC testimony was supportive with amendments. The Reference Committee agrees with testimony to amend the first resolve to change “advocate” to “support.” The focus on equitable reimbursement in the resolve clauses is not supported by the whereas clauses. Insufficient coverage is cited as the primary barrier to access, not equitable reimbursement. We agree with testimony to amend the second resolve clause to support the authors’ aims regarding reimbursement of gender-affirming procedures by amending existing policy. The Reference Committee recommends the addition of a third resolve clause, wherein existing policy is amended to support removal of an additional barrier to coverage of gender-affirming procedures, to strengthen the ask. Resolution 011 at the current House of Delegates Meeting also addresses “informed consent” model for coverage. Your Reference Committee recommends Substitute Resolution 061 be adopted in lieu of Resolution 061.

(44) CME REPORT A- RESIDENCY APPLICATION SUPPORT FOR STUDENTS OF LOW-INCOME BACKGROUNDS

RECOMMENDATION:

Substitute Recommendations be adopted in lieu of CME Report A and the remainder of the report be filed:

RESOLVED, That our AMA advocate for residency application platforms that are no-cost to all residency applicants; and be it further
RESOLVED, That our AMA support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services.

Your Committee on Medical Education recommends that the following recommendations are adopted as amended as follows and the remainder of this report is filed:

RESOLVED, That our AMA supports advocate to relevant stakeholders for the 1) The creation of a fee assistance or fee waiver program Fee Assistance Program for ERAS and or funding opportunities for to support students of low-income backgrounds as they apply for residency. 2) Encouraging medical schools to provide similar funding opportunities and or scholarships for students of low-income backgrounds for their residency applications.

VRC testimony was in support of the recommendations with amendments. The Reference Committee agrees with testimony to advocate for a more equitable medical education system. The report makes a strong case for the burden of application fees on students. While questions were raised about how administrative costs may be managed, this question was thought to not be a significant barrier given the goal of supporting equity. Your Reference Committee recommends the Substitute Recommendations be adopted in lieu of CME Report A and the remainder of the report be filed.
RECOMMENDED FOR REFERRAL

(45) RESOLUTION 006 - MEDICAID MANAGED CARE FOR INDIAN HEALTH CARE PROVIDERS

RECOMMENDATION:

Resolution 006 be referred.

RESOLVED, Our AMA suggests that CMS to direct state Medicaid agencies with Medicaid Managed Care Organizations (MCO) to:

(a) Recognize the importance of onboarding and annual refresher training regarding Indian Health Care Medicaid Managed Care Provisions (42 C.F.R. § 438.14)

(b) Consider the enrollment of in-state and neighboring-state Indian Health Care Providers (IHCPs) as in-network.

(c) Suggest that Indian Health Care Providers (IHCPs) be paid at the in-network rate and not less than the amount the MCO would pay to a non-IHCP, regardless of IHCP network status.

(d) Share best practices for working with Indian Health Care Providers (Indian Health Service, Tribal, and Urban Indian Health Programs) between Medicaid Managed Care Organizations.

(e) Consider convening a Tribal Advisory Committee or hire a Tribal liaison to facilitate care coordination agreements and payment for managed care services.

(f) Consider utilizing the CMS Indian Managed Care Addendum to facilitate agreements between MCOs and IHCPs.

RESOLVED, Our AMA suggests CMS to direct state Medicaid agencies planning to implement or with Medicaid Managed Care Organizations to engage in robust and meaningful Tribal consultation; and be it finally

RESOLVED, Our AMA suggests CMS to conduct regular audits of Medicaid Managed Care Organizations to ensure compliance with Indian Health Care Medicaid Managed Care Provisions, including, but not limited to, correction of claims, development of new policies and processes, and evaluation and measurement tools.

VRC testimony was mixed in support of amendments and referral. Your Reference Committee agrees with testimony that the asks of the resolve clauses are not backed up by the evidence in the whereas clauses. We agree with VRC testimony that these asks may have economic consequences that are not fully considered by the evidence presented as currently written. The language in the first resolve also had concerns of feasibility in being too prescriptive without the evidence to support the ask, including the need for a Tribal Advisory Committee or refresher training programs. There were concerns that the asks are not supportive or consistent with the Indian Health Care
Improvement Act. Your Reference Committee considered additional language that was offered in VRC testimony in the form of a substitute resolution, although we found that these asks were still not supported by current evidence provided and would benefit from further study to clarify the intent of the asks. We agreed that this item should be referred to improve evidence and send forward a feasible ask. The Reference Committee recommends Resolution 006 be referred.

(46) RESOLUTION 007 - INCREASED HEALTH PRIVACY ON MOBILE APPS IN LIGHT OF ROE V. WADE

RECOMMENDATION:

Resolution 007 be referred.

RESOLVED, That AMA policy H-480.943 be amended by addition and deletion as follows:

Integration Addressing of Mobile Health Applications and Devices Into Practice H-480.943

1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.

2. Our AMA supports that mobile mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical and/or personally identifying information.

3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials
to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mobile mHealth apps, and how their information and data can potentially be collected and used, including period-tracking apps that could be used to identify pregnancies.

4. Our AMA encourages the mobile mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information and/or personally identifying information.

5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mobile mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.

6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mobile mHealth apps that he or she prescribes, recommends, or discuss with patients and document the patient’s understanding of such risks.

7. Our AMA supports further development of research and evidence regarding the impact that mobile mHealth apps have on quality, costs, patient safety and patient privacy.

8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mobile mHealth apps and associated devices into care delivery.

RESOLVED, That AMA policy D-315.968 be amended by addition as follows:

Supporting Improvement to Patient Data Privacy D-315.968
Our AMA will strengthen patient and physician data privacy protections by advocating for legislation that reflects the AMA’s Privacy Principles with particular focus on mobile health apps and other digital health tools, in addition to non-health apps and software capable of generating patient data.

VRC testimony was mixed. The Reference Committee agrees with testimony that “mobile apps” are a broad category and it would not be within the scope of the AMA to advocate for their regulation. We also noted that some of the policy clauses that the first resolved clause seeks to amend may not be logical to amend to “mobile” from “mHealth”, such as clause 5, 7 and 8. We would ask relevant committees to further answer the following questions 1) What is the most appropriate definition for platforms which might be able to share or generate personally identifying information? 2) How do non-health apps generate patient data? 3) How do the asks of this resolution advance upon or differ from the AMA’s published Privacy Principles by Design which are broad and can cover non-health applications? After reviewing the Board of Trustees Report 04, your Reference Committee recommends that Resolution 007 be referred.
(47) RESOLUTION 009 - NEW POLICIES TO RESPOND TO THE GUN VIOLENCE PUBLIC HEALTH CRISIS

RECOMMENDATION A:

The first Resolve of Resolution 009 be adopted.

RECOMMENDATION B:

The Second Resolve of Resolution 009 be referred.

RESOLVED, That our AMA support evidence-based community firearm violence interruption programs and hospital-based violence interruption programs; and be it further

RESOLVED, That our AMA support the institution of evidence-based policies on gun inheritance, the limitation on purchases through multiple sales, and the implementation of background checks for ammunition purchase.

VRC testimony was mixed. The Reference Committee agrees with testimony that the second resolve clause is open to interpretation and should be clarified based on the whereas clauses. Additionally, the Reference Committee recommends referral of the second resolve clause to study and provide statistical data on the following questions: 1) What is the contribution of gun inheritance firearms to firearm crimes? 2) What is the contribution of straw purchase firearms to domestic firearm crimes? 3) What might be the burden to NICS background check system (or other prospective system) be with incorporation of ammunition background checks for ammunition purchases? 4) What are current state laws regarding the above policies and are there natural experiments to inform policies looking forward? Your Reference Committee recommends adoption of the first resolve and referral of the second resolve of Resolution 009 as amended.

(48) RESOLUTION 010 - AGAINST DIRECT CONTRACTING ENTITIES

RECOMMENDATION:

Resolution 010 be referred.

RESOLVED, That our AMA oppose any attempts to implement Direct Contracting Entities, such as Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-REACH) program, and their relationship with Medicare; and be it further

RESOLVED, That our AMA develop educational materials for physicians regarding Direct Contracting Entities, such as Accountable Care Organization Realizing Equity,
Access, and Community Health (ACO-REACH) program so that they are aware of the implications of their individual or their employer’s participation in this program; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

VRC testimony was mixed. The Reference Committee agrees with testimony that the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-REACH) program is complex and not characterized correctly in the resolution. We agree with testimony that the program has not been implemented and so the downstream impacts cannot be clearly addressed at this time. Questions for committees to consider include: 1) How do we most clearly define the distinction between Medicare Advantage, GPDC, and ACO-REACH? 2) What should our policy be regarding the involvement of business interests in administering public insurance? 3) What are the unique attributes of the ACO-REACH model in terms of governance requirements for notification of patients and providers given no loss of traditional Medicare benefits? These questions are non-exhaustive on this complex and important matter. Your Reference Committee recommends Resolution 010 be referred.

(49) RESOLUTION 019 - REGULATION OF SKIN BLEACHING AGENTS AND COLORISM AS A PUBLIC HEALTH CONCERN

RECOMMENDATION:

Resolution 019 be referred.

RESOLVED, That our AMA recognizes skin bleaching as a public health concern among people of color populations; and be it further

RESOLVED, That our AMA discourages the excessive use of skin bleaching agents for cosmetic or other non-medical purposes; and be it further

RESOLVED, That our AMA collaborates with appropriate stakeholders to enhance education about the dangers of skin bleaching to skin of color patients and health care providers; and be it further

RESOLVED, That our AMA supports the continued efforts to regulate skin bleaching and/or lightening agents; and be it further

RESOLVED, That our AMA amend Policy H-65.952, “Racism as a Public Health Threat” by addition to read as follows:
Racism and Colorism as a Public Health Threat, H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and colorism within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism and colorism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism and colorism; and (b) how to prevent and ameliorate the health effects of racism and colorism.

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

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

VRC testimony was mixed with significant feedback that the fifth resolve be re-crafted as a standalone policy. The Reference Committee agree with testimony that the whereas clauses do not contain sufficient evidence for the asks of this resolution. Of note, the studies cited were mainly performed in countries outside of the United States and domestic data is required to characterize the scope and impact of the resolution. US-specific data is required to clarify the prevalence of the practice of skin lightening domestically, the health impact due to this practice, and the potential amelioration that can be reached with the passage of this resolution. Your Reference Committee recommends Resolution 019 be referred.

(50) RESOLUTION 022 - AMENDING POLICY H-80.999, “SEXUAL ASSAULT SURVIVORS” TO IMPROVE KNOWLEDGE AND ACCESS TO NO-COST RAPE TEST KITS

RECOMMENDATION:

Resolution 022 be referred.

RESOLVED, That our American Medical Association amend Policy H-80.999, “Sexual Assault Survivors,” by addition to read as follows:
1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

4. Our AMA will (a) advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations; (b) support and advocate appropriate stakeholders, such as the Health Resources and Services Administration, the United States Government Accountability Office, and the Office on Violence Against Women, in the creation and implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers.

5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of “backlogged” sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

VRC testimony was mixed. While the creation of a national database is a novel, the Reference Committee agrees with testimony that the resolution as written does not change AMA’s advocacy efforts significantly and there are unintended consequences of breaches in privacy or risks to healthcare delivery organizations to be considered. We believe there is evidence that needs to be included to address these concerns that may benefit from the resources of an MSS study. Questions for committees to address include: 1) What is the precedent for creating databases of providers to increase accessibility and utilization of a service? 2) Are there other innovations that may be considered to increase accessibility of SAFE and SANE services? 3) Are there existing databases for this purpose that are not national? Your Reference Committee recommends Resolution 022 be referred.
(51) RESOLUTION 025 - STUDYING EFFECTS OF ONLINE EDUCATION ON MEDICAL EDUCATION OUTCOMES DURING COVID-19 PANDEMIC

RECOMMENDATION:

Resolution 025 be referred.

RESOLVED, that our AMA support research on how distance learning impacted undergraduate medical education outcomes including standardized test scores, mental health, and self-efficacy.

VRC testimony was in favor of referral. The Reference Committee agrees with testimony that the resolve clause as written lacks an objective. Questions for referral include: 1) Is the goal to understand the efficacy of online education modalities, or whether medical education has suffered as a result of online modalities? 2) Is the goal to research hybrid education and learning modalities? 3) What data might be drawn upon for such studies beyond test score and match rates? Council on Medical Education supported referral in testimony. Thus, your Reference Committee recommends Resolution 025 be referred.

(52) RESOLUTION 026 - SPECIAL DIABETES PROGRAM FOR INDIANS

RECOMMENDATION:

Resolution 026 be referred.

RESOLVED, our AMA supports permanent reauthorization of the Special Diabetes Program for Indians; and be it further RESOLVED, our AMA supports biannual inflationary increases for public health and health profession grants sponsored by the Indian Health Service.

VRC testimony was mixed. While the Reference Committee supports the spirit of the resolution, the Reference Committee recommends a study of Resolution 026 to clarify the permanent reauthorization of the program, address the issue of advance appropriations as mentioned by the authors, and address questions regarding inflation adjustment. We discussed the possibility of permanent reauthorization changing funding avenues and the potential consequences of this. We also noted evidence regarding the percentage of funding from the SDPI that has gone towards inflation in references cited but was not addressed completely in the whereas clauses. Questions for committees to answer include: 1) What precedent is there for permanent reauthorization of federal health programs? 2) Would it be more comprehensive for the AMA to advocate for advance appropriations for all IHS programs to allow for proper budgeting? 3) To adequately account for inflation, how often should the budget be updated or does policy
need to be this specific? Your Reference Committee recommends Resolution 026 be referred.

(53) RESOLUTION 030 - RESEARCH OF PLASTIC USE IN MEDICINE

RECOMMENDATION:

Resolution 030 be referred.

RESOLVED, That our AMA amend by addition as follows:

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages research into methods on the reduction of single-use plastic in medicine and the effects of microplastics on human health; (15) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (16) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (167) encourages expanded funding for environmental
research by the federal government; and (178) encourages family planning through national and international support.

VRC testimony was in support of the resolution’s spirit. The Reference Committee agrees with testimony that “single-use plastic” was not mentioned in the resolve clauses and this resolution would benefit from further study and clarification. The Reference Committee also notes pending transmittal 24 on single-use devices in the OR which may address this portion of the asks of this resolution. The Reference Committee recommends that the committee(s) to which this is referred focus on climate change related literature to accomplish the asks of this resolution that go beyond those of our existing and pending policies. Your Reference Committee recommends resolution 030 be referred.

(54) RESOLUTION 042 - ADVOCATING FOR HEALTH COVERAGE EXPANSION FOR POST-COVID (LONG-COVID) CONDITIONS

RECOMMENDATION A:

The first Resolve of Resolution 042 be amended by deletion:

RESOLVED, That our AMA advocate to maintain coverage benefits for patients with Post-COVID Conditions (PCC) as expanded in the American Rescue Plan; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 042 be referred.

RESOLVED, That our AMA advocate to maintain coverage benefits for patients with Post-COVID Conditions (PCC) as expanded in the American Rescue Plan; and be it further

RESOLVED, That our AMA advocate for changing Social Security Disability Insurance and Supplemental Security Income qualification criteria to maximize Post-COVID Conditions (PCC) inclusion for disability benefits.

VRC testimony was supportive of the resolution with amendments. The Reference Committee agrees with testimony that the first resolve clause should be struck because it will not add to the AMA’s advocacy efforts. Concerns were also raised regarding tying insurance benefits to a specific pre-existing condition. We also agree with testimony that the second resolve clause should be referred for study to consider inclusion and costs for other conditions beside Post-COVID Conditions. The following questions would need to be addressed: 1) What is the current landscape of SSDI and SSI eligibility? 2) How do duration requirements for actual or expected disability get evaluated and reported? 3)
What might be the costs of reducing duration of disability requirements for other conditions besides Post-COVID? 4) Are there analogous changes that have been made to SSI/SSDI that have led to broader coverage for specific conditions and how were these accomplished? Your Reference Committee recommends Resolution 042 be referred.

(55) RESOLUTION 045 - INCREASE RESIDENT PHYSICIAN PAY

RECOMMENDATION A:

The second Resolve of Resolution 045 be amended by deletion:

RESOLVED, That our AMA, to improve their commitment to representing all physician at all points of their training, amend AMA policy H310.912 (Resident Bill of Rights): Resident Bill of Rights, H310.912

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual’s training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels) to be directly competitive with midlevel providers at equal postgraduate training levels.

RECOMMENDATION B:

The first Resolve of Resolution 045 be referred.

RESOLVED, That our AMA, to improve their commitment to representing all physician at all points of their training, amend AMA amend policy H310.912 (Resident Bill of Rights):

Resident Bill of Rights, H310.912

E. Adequate compensation and benefits that provide for resident well-being and health.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living, tied to the federal rate of inflation as outlined by the U.S. Department of Labor.

and be it further
RESOLVED, That our AMA, to improve their commitment to representing all physician at all points of their training, amend AMA policy H310.912 (Resident Bill of Rights):

Resident Bill of Rights, H310.912
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels) to be directly competitive with midlevel providers at equal post-graduate training levels.

VRC testimony was supportive of the resolution with amendments. The Reference Committee agrees with testimony to refer the first resolve clause because the link to inflation is not supported well enough by the whereas clauses. We agree with testimony to strike the second resolve clause because it does not significantly change our existing policy. Your Reference Committee notes a related resolution proposed by Arkansas in the House of delegates, Resolution 307. Should this resolution be referred for study, MSS committees may elect to request further study in lieu of an internal study via council communication. You Reference Committee recommends that Resolution 045 be referred for further study.

(56) RESOLUTION 085 - AGAINST LEGACY PREFERENCES AS A FACTOR IN MEDICAL SCHOOL ADMISSIONS

RECOMMENDATION:

Resolution 085 be referred.

RESOLVED, our AMA-MSS amend policy 295.169MSS as follows:

Eliminating Legacy Admissions, 295.169MSS
Our AMA oppose AMA-MSS will ask the AMA to oppose the use consideration of legacy status in medical school admissions and to support mechanisms to eliminate its inclusion from the application process such as by encouraging medical schools, the AAMC, AACOM, LCME, and the AACOM, and other relevant stakeholders to remove any questions on secondary applications pertaining to legacy status.

VRC testimony was in favor of referral. The House Coordination Committee placed this resolution on the reaffirmation calendar. The Reference Committee disagrees with this recommendation of reaffirmation of 295.169MSS since Resolution 085 seeks to reintroduce this as external policy with the addition of medical schools, which is a significant change from internal MSS policy. Discussion of a prior similar HOD
Resolution 902 that was introduced during the interim meeting of 2012 brought up concerns that legacy status was used in a preferential or inappropriate way during the application process. Resolution 085 has the opportunity to address these concerns, although we agree that there needs to be more robust evidence to address understanding the relationship between legacy status and medical school admissions. There are differences between undergraduate and medical school admissions processes that can be explored further to include current specific data on medical school admissions. The Reference Committee agrees with testimony that the resolution should be studied to include more research to support the asks. Your Reference Committee recommends Resolution 085 be referred.
RECOMMENDED FOR NOT ADOPTION

(57) RESOLUTION 005 - ADVOCATING FOR UTILIZATION OF STATE-LEVEL WAIVERS IN POST-COVID-19 COVERAGE PROTECTION

RECOMMENDATION:

Resolution 005 not be adopted.

RESOLVED, That our AMA advocate for relevant legislative bodies, state medical societies, and stakeholders in utilizing CMS Section 1902(e)(14) waivers at the state-level; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the I-22 AMA House of Delegates.

VRC testimony was mixed between opposition and supporting with amendments. The Reference Committee agrees with testimony that the language is too prescriptive and this should not be immediately forwarded at this time due to feasibility concerns. While an important mechanism to support maintaining Medicaid benefits for members, these waivers have already been adopted by 27 States, and it is not clear what barriers are preventing the remaining states. Supporting the transition to other affordable healthcare options and maintaining coverage after the Public Health Emergency (PHE) ends is already a cornerstone of the AMA’s healthcare policy efforts (2022 and Beyond: AMA’s Plan to Cover the Uninsured). Furthermore, after the PHE ends there will still be a year of coverage for these patients, which removes the need for immediate forwarding. Your Reference Committee recommends Resolution 005 not be adopted.

(58) RESOLUTION 023 - SPECIALIZED PSYCHIATRIC FACILITIES FOR PREGNANT AND POSTPARTUM INDIVIDUALS

RECOMMENDATION:

Resolution 023 not be adopted.

RESOLVED, That our AMA amend current policy H-420.953, “Improving Mental Health Services for Pregnant and Postpartum Mothers” by insertion and deletion as follows:

Improving Mental Health Services for Pregnant and Postpartum Mothers, H-420.953

Our AMA: (1) supports improvements in current mental health services development of inpatient, partial hospitalization, and intensive outpatient psychiatry centers which are specialized in the treatment of pregnant individuals
and postpartum psychiatric disorders including postpartum psychosis and
postpartum depression, particularly in states that currently lack these facilities for
women during pregnancy and postpartum; (2) supports advocacy for inclusive
insurance coverage of mental health services during gestation, and extension of
postpartum mental health services coverage to one year postpartum; (3)
supports appropriate organizations working to improve awareness and education
among patients, families, and providers of the risks of mental illness during
gestation and postpartum; and (4) will continue to advocate for funding programs
that address perinatal and postpartum depression, anxiety and psychosis, and
substance use disorder through research, public awareness, and support
programs; and (5) encourages development of protocols and infrastructure to
provide prompt access to specialized resources and treatment for pregnant and
postpartum patients in psychiatric crisis situations.

VRC testimony was in opposition to the resolution as written. The American Psychiatric
Association (APA) offered testimony in favor of maintaining mental health services and
not being prescriptive in clause one. Calling for specific advocacy for these facilities alone
could dilute this broad policy and evidence of the costs, benefits, and coverage for these
specialized facilities was not included in the resolution. The addition of clause 5 was also
not considered to add an additional imperative beyond the original language of this policy
and D-420.991. Thus, Your Reference Committee recommends that Resolution 023 not
be adopted.

(59)    RESOLUTION 024 - BILLING FOR TRADITIONAL HEALING SERVICES

RECOMMENDATION:

Resolution 024 not be adopted.

RESOLVED, Our AMA advocate that federal laws be enacted that would authorize
payment from the Indian Health Service for traditional healing services provided by
Indian Health Service, Tribal, and Urban Indian Health Programs; and be it finally

RESOLVED, Our AMA place as an advocacy priority of its organization that county and
state medical societies and American Indian and Alaska Native Tribes and Villages
encourage state Medicaid programs and managed care organizations to cover traditional
healing services provided at Indian Health Service, Tribal, and Urban Indian Health
facilities.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the
evidence of traditional healing practices is limited and that the argument presented did
not include evidence-based interventions or implications for the safety and regulation of
these services. There was also discussion of how the coverage of these services would
compare to other preventative medicine, emphasizing the need to further develop the
evidence-base for the clinical efficacy of these services in this population. As there is a
gap in the evidence needed to address these concerns, the Reference Committee
recommend that the authors workshop the resolution to provide further clarification on
clinical efficacy and what qualifies as a traditional healing service. The Reference
Committee recommends Resolution 024 be not adopted.

(60) RESOLUTION 040 - CHANGING MEDICAL SCHOOL DRUG TESTING
POLICIES

RECOMMENDATION:

Resolution 040 not be adopted.

RESOLVED, our AMA-MSS will ask the AMA to 1) advise against the practice of pre-
matriculation drug screening and random drug testing in medical schools and 2) advocate
that reasonable suspicion of impairment is required to request a drug test for medical
students.

VRC testimony was in opposition to the resolution as written. The Reference Committee
agrees with concerns of feasibility and possible harms caused by clause two, as a
requirement of “reasonable suspicion of impairment” is subjective and may
unintentionally and disproportionately impact marginalized groups. We also discussed
that asking the AMA to take a stance on drug screenings and testing in this context is
not within the scope of the AMA, and does not have sufficient support within the whereas
clauses. We also agree with testimony that the resolution overall lacks enough evidence
for the stated asks and that the intent of the resolution be clarified. The whereas clauses
only address marijuana and alcohol, and there was not sufficient research provided on
the impact on halting drug testing for students entering a career which will also require
drug testing. Your Reference Committee recommends Resolution 040 not be adopted.

(61) RESOLUTION 043 - RESEARCHING NEW CCHD SCREENING PRACTICES IN
PIGMENTED NEONATES

RECOMMENDATION:

Resolution 043 not be adopted.

RESOLVED, That our AMA support the research of utilizing alternatives to pulse oximetry
as a CCHD screening tool due to the overestimated oxygen saturation in pigmented
individuals, such as echocardiography; and be it further
RESOLVED, That our AMA support the research of appropriate oxygen saturation targets variable by pigmentation in neonates to decrease the risk of occult hypoxemia in pigmented neonates.

VRC testimony was mixed. The Reference Committee observed that the study limitations in the substantiating evidence referenced in the Whereas clauses skewed the impact, but agreed that prior AMA priorities deemed the subject matter pertinent for examination. The Reference Committee debated whether the resolution already had coverage under H-460.909, “Comparative Effectiveness Research”, as it allows for revision of clinical and public health interventions as a whole, with consideration for race, ethnicity, gender, age, and economic status. Further discussions also highlighted overlap with D–350.981, “Racial Essentialism in Medicine”. Your Reference Committee agrees with testimony that this resolution as written would not change AMA’s advocacy efforts. The Reference Committee encourages the authors to strengthen the evidence referenced in the Whereas clauses and resubmit this resolution at A-23. Your Reference Committee recommends Resolution 043 not be adopted.

(62) RESOLUTION 048 - DISCUSSIONS ON ELECTIVE STERILIZATION IN UNDERGRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Resolution 048 not be adopted.

RESOLVED, That our AMA encourages the inclusion of female sterilization education as a part of medical school curricula; and be it further

RESOLVED, That our AMA develops guidelines and resources to support curricula that address physician bias in the topic of female sterilization in medical schools.

VRC testimony was in opposition to the resolution. The Reference Committee agrees with testimony that this resolution lacks evidence that current medical school curricula are lacking in education on female sterilization. We also agreed that developing guidelines that address physician bias is not likely to change advocacy on this topic, as the AMA already has policy addressing physician bias. We support the spirit of this resolution but share concerns that both resolved clauses are not sufficiently supported by the whereas clauses. Your Reference Committee recommends that Resolution 048 not be adopted.

(63) RESOLUTION 052 - IMPROVING CARDIOVASCULAR SCREENINGS BY INCLUDING LIPOPROTEIN(A) (LP(A))

RECOMMENDATION:
Resolution 052 not be adopted.

RESOLVED, Our AMA advocates medical providers add a one time screening for Lp(a) to one lipid panel run on each patient when deemed beneficial under their clinical judgment as it pertains to current literature; and be it further

RESOLVED, Our AMA urges the Centers for Medicare and Medicaid Services (CMS) to extend coverage of cardiovascular risk assessment to include Lp(a) screening when deemed clinically beneficial.

RESOLVED, That our AMA amend H-425.990 by addition:

Prevention of Coronary Artery Disease H-425.990
The AMA believes that (1) total serum cholesterol, High Density Lipoprotein-Cholesterol (HDL-C), triglycerides, and Low Density Lipoprotein-Cholesterol (LDL-C) should be measured under supervision of a physician, with proper safeguards for quality assurance and (2) when serum cholesterol levels are excessive, appropriate measures should be taken to educate the patient concerning methods to improve serum lipids and thereby reduce the risk of coronary heart disease, and, additionally, (3) serum Lipoprotein (a) should be measured when deemed beneficial for prevention of future coronary events under the supervising physician’s clinical judgment.

VRC testimony was in opposition to the resolution. The House Coordination Committee placed this resolution on the reaffirmation calendar. The Reference Committee agrees with testimony that there is a lack of evidence to support this resolution and it is outside of the AMA’s scope as it dictates guidelines that are in the purview of specialty societies. We agree with testimony that specialty societies are the correct body to bring this resolution forward. Furthermore, authors presented sources which were noted by testimony on VRC that Lp(a) does not have evidence to support clinical outcomes and current tests have low reliability between samples. Thus, your Reference Committee recommends Resolution 052 not be adopted.

(64) RESOLUTION 053 - ENSURING BASIC OPHTHALMOLOGY TRAINING IN MEDICAL EDUCATION

RECOMMENDATION:

Resolution 053 not be adopted.

RESOLVED, That our AMA will work with stakeholders to promote education in ophthalmology and supports integrating training in ophthalmology in medical education, to promote competency in screenings for oculopathies.
VRC testimony was mixed. The Reference Committee agrees with testimony that this resolution is outside of the AMA’s scope and would be more successful if brought forward by a specialty society. It is neither feasible nor appropriate for the AMA to promote this specific curriculum to medical schools without specialty society support. Additionally, evidence presented in the whereas clause and on the VRC make it clear that ophthalmology curriculum was already included in medical education and would not significantly change advocacy efforts. Your Reference Committee recommends Resolution 053 not be adopted.

(65) RESOLUTION 056 - ENSURING FAIR OPPORTUNITIES FOR INTERNATIONAL MEDICAL STUDENTS

RECOMMENDATION:

Resolution 056 not be adopted.

RESOLVED, That our AMA will encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students; and be it further

RESOLVED, That our AMA will amend policy H-255.968 “Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools”; and be it further

Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968

Our AMA:
1. supports the autonomy of medical schools to determine optimal tuition requirements for international students;
2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;
3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and
4. encourages medical schools to minimize the use of prepayment requirements, such as escrow accounts, unless deemed truly necessary; and
5. encourages medical schools that continue to require prepayment to consider requesting only one year of prepayment at a time, rather than all four years at once; and
4. 6. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years for covering the costs of medical school.
RESOLVED, That our AMA will urge organizations that administer medical student scholarships to also allow international medical students to apply for those scholarships.

VRC testimony was mixed. The AMA already has extensive policy supporting international students and physicians, making the first resolve not a novel addition (D-255.980) and was recently reaffirmed. The Reference Committee agrees with testimony that the second resolve is contradictory of current policy and its adoption would suggest specific tuition requirements within policy supporting the autonomy of medical schools. We agree with testimony that the third resolve clause is out of the AMA’s scope as it would not be appropriate for the AMA to direct eligibility criteria for scholarships offered by other institutions. Recognition of the opposing viewpoints for why prepayment requirements may be considered necessary for financial institutions was not presented making the policy challenging to stand on its own. Your Reference Committee recommends Resolution 056 not be adopted.

(66) RESOLUTION 057 - USE OF ICD AND CPT CODES TO IMPROVE RESPONSE TO HUMAN TRAFFICKING

RECOMMENDATION:

Resolution 057 not be adopted.

RESOLVED, That our AMA supports increased utilization of the International Classification of Diseases (ICD) codes that describe suspected and confirmed cases of human trafficking; and be it further

RESOLVED, That our AMA supports the use of electronic health record data which references suspected or confirmed human trafficking by relevant stakeholders in the development of targeted services and resources to address the needs of victims; and be it further

RESOLVED, That our AMA study the development of physician reimbursement models that support anti-trafficking efforts including victim identification, intervention, and referral.

VRC testimony was limited and mixed. The Reference Committee supports the spirit of the resolution, but we have concerns about the feasibility and implementation of the asks. We discussed testimony that pointed out concerns with the second resolve clause with regards to compromised safety for the victims of “suspected” human trafficking, and its impact on HIPAA. Further, there were concerns for the willingness of physicians to use these ICD codes in such instances of human trafficking, and that the impact of these resolves would be inadvertently harmful for these victims and their privacy. Lastly, the
reference to CPT codes may represent a conflict of interest for the AMA as the publisher
of said code book. Your Reference Committee recommends Resolution 057 not be
adopted.

(67) RESOLUTION 059 - SUPPORT FOR MEDICARE EXPANSION TO
WHEELCHAIR ACCESSIBILITY HOME MODIFICATIONS AS DURABLE
MEDICAL EQUIPMENT

RECOMMENDATION:

Resolution 059 not be adopted.

RESOLVED, That our AMA amend current policy Protecting Patient Access to Seat
Elevation and Standing Features in Power Wheelchairs D-330.899 to state the following

Protecting Patient Access to Seat Elevation and Standing Features in
Power Wheelchairs D-330.899
Our AMA: (1) will request that the Centers for Medicare and Medicaid Services
render a benefit category determination that establishes that the seat elevation,
standing features of power wheelchairs, and installation of wheelchair ramps are
primarily medical in nature and qualify under the definition of durable medical
equipment when used in a power wheelchair.

VRC testimony was mixed. The Reference Committee agrees with testimony that the
amendment to D-330.899 does not align with the policy’s intent because wheelchair
ramps are not a component of wheelchairs. The ask of this resolution regarding
evidence for the addition of wheelchair ramps is not sufficiently supported by the
whereas clauses and could be accomplished by amending a different existing policy.
The intention and implications of changing ramps to being considered durable medical
equipment was not adequately addressed. Your Reference Committee recommends
Resolution 059 be not adopted.

(68) RESOLUTION 067 - INTRODUCTION OF PRE-DISCHARGE INDIVIDUALIZED
FALL RISK ASSESSMENTS FOR OLDER ADULTS

RECOMMENDATION:

Resolution 067 not be adopted.

RESOLVED, Our AMA encourages interprofessional, individualized fall assessment
protocols, such as STEADI, in inpatient settings when preparing patients for discharge to
reduce injury and financial burden.
VRC testimony was in opposition to the resolution. The Reference Committee agrees with testimony that the resolves are not supported by the whereas clauses and the list of sources lacks diversity. VRC testimony mentioned concern over the current language reading to suggest setting guidelines, which may not be within the scope of the AMA. We discussed that it is unclear which population these protocols would benefit and the concern for limited evidence on the specific suggested fall assessment protocol in the ask. It would benefit the authors to clarify their intent for this ask. The Reference Committee recommends Resolution 067 not be adopted.

(69) RESOLUTION 072 - SLEEP DEPRIVATION AS A PUBLIC HEALTH CRISIS

RECOMMENDATION:

Resolution 072 not be adopted.

RESOLVED, That our AMA partner with stakeholder organizations, such as but not limited to the Centers for Disease Control and Prevention, the American Academy of Sleep Medicine, and the National Sleep Foundation, to promote sleep deprivation as a public health crisis for all age groups.

VRC testimony was limited and mixed. Your Reference Committee agrees with testimony that declaring sleep deprivation as a public health crisis will not significantly change the AMA’s advocacy efforts. The clause lacks a clear policy objective besides promoting the issue and declaring it a crisis alone, and the reference committee notes there are already policies for specific age groups. The Reference Committee recommends Resolution 072 not be adopted.

(70) RESOLUTION 074 - ENCOURAGING THE TRANSITION FROM ARTIFICIAL TURF TO NATURAL GRASS SURFACES FOR ATHLETIC USE

RECOMMENDATION:

Resolution 074 not be adopted.

RESOLVED, that our AMA supports the use of natural grass over artificial turf in all youth, high school, college, and professional athletic facilities and encourages the use of artificial turf in their facilities to transition to natural grass fields; and be it further

RESOLVED, that our AMA encourage injury prevention training while utilizing artificial turf in areas where transition to natural grass fields is not possible.

VRC testimony was in opposition to the resolution as written. The Reference Committee agrees with concerns that the resolution lacks sufficient evidence regarding the cost and
feasibility of installation, maintenance, and transition to natural grass in varying regions of different climates and resources. The second resolve clause is not backed up by evidence in the whereas clauses and could benefit from clarification of its intent. The AMA also has existing policies regarding injury prevention and concussion management. Your Reference Committee recommends Resolution 074 not be adopted.

(71) RESOLUTION 078 - MENTAL HEALTH PROTOCOLS FOR SURGERY

RECOMMENDATION:

Resolution 078 not be adopted.

RESOLVED, That our AMA encourages the use of an existing mental health screening prior to and following all non-emergent surgeries as a preventative measure to provide both the physician and patient insight into the mental fortitude of the patient prior to surgery as well as their ability to cope with the gravity of their situation following the procedure.

VRC testimony was in opposition to the resolution. The Reference Committee agrees with concerns that the resolution is outside of the AMA’s scope and lacks sufficient evidence. We discussed that the resolve is not feasible as it is asking the AMA to encourage the use of existing screenings without the proper evidence or support from specialty societies. The resolution also risks further stigmatizing patients needing surgical intervention. Your Reference Committee recommends Resolution 078 not be adopted.

(72) RESOLUTION 080 - AMEND AMA-MSS 65.017 TO EXPAND LGBTQ+ HEALTH TRAINING

RECOMMENDATION:

Resolution 080 not be adopted.

RESOLVED, Our AMA-MSS advocate for the AMA to broaden the scope of LGBTQ+ health training programs to include education on LGBTQ+ biopsychosocial health needs for all patient-facing roles by amending Policy 65.017MSS, “LGBTQ+ Patient Specific Training Programs for Healthcare Providers, as follows:”

LGBTQ+ Patient Specific Training Programs for Healthcare Providers, 65.017MSS

AMA-MSS will ask the AMA to support the training of healthcare providers and all other patient-facing roles in cultural competency as well as in physical biopsychosocial health needs for LGBTQ+ patient populations.
VRC testimony was mixed. The Reference Committee agrees with testimony that adding all patient-facing roles to existing policy is vague and is outside the AMA’s scope. Asking the AMA to broaden the scope of training programs may not be an appropriate avenue of achieving the intent of this resolution, as this is also not within the AMA’s purview. There is also little evidence offered for how the inclusion of the biopsychosocial model in training programs benefits current healthcare practices. This addition to internal policy as written is not likely to change advocacy efforts in this area, and it may benefit the authors to clarify the intent of their resolution. Your Reference Committee recommends Resolution 080 not be adopted.

(73) RESOLUTION 081 - ESTABLISHMENT OF A CLIMATE CHANGE STANDING COMMITTEE

RECOMMENDATION:

Resolution 081 not be adopted.

RESOLVED, That our AMA-MSS create a climate change standing committee.

VRC testimony was mixed. The Reference Committee agrees with VRC testimony that the proper avenue for the creation of a MSS Standing Committee is through an MSSAI after review of IOP 7, as it is more appropriately within the purview of the MSS Governing Council. Your Reference Committee recommends Resolution 081 not be adopted.

(74) RESOLUTION 083 - ESTABLISHING AND MAINTAINING PATIENT LIBRARIES IN HOSPITALS

RECOMMENDATION:

Resolution 083 not be adopted.

RESOLVED, That our AMA support research into the utility of patient libraries in the hospital setting and their impact on patients’ health and hospital experience.

VRC testimony was mixed. The Reference Committee agrees with testimony that the resolution lacks evidence to substantiate the whereas clauses. Furthermore, your Reference Committee noted that some evidence cited is inconsistent with the conclusions drawn, for example regarding the benefits of academic library access for clinicians while the resolution addresses patient libraries. We agree with testimony from the American Psychiatric Association (APA) that this resolution would benefit from researching the utility and cost effectiveness of patient libraries compared to other resources. Your Reference Committee recommends Resolution 083 be not adopted.
RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(75) RESOLUTION 008 - SUPPORTING LEGISLATIVE AND REGULATORY EFFORTS AGAINST FERTILITY FRAUD

RECOMMENDATION:

Policy H-320.951 be reaffirmed in lieu of Resolution 008.

RESOLVED, Our AMA acknowledges and opposes physicians using their own sperm to artificially inseminate patients without proper explicit and informed patient consent, otherwise known as illicit insemination or fertility fraud; and be it further

RESOLVED, Our AMA supports legislative and regulatory efforts to protect patients from physicians and healthcare practitioners who inseminate their own sperm into patients without their consent.

VRC testimony was in support of the spirit of the resolution. The Reference Committee agrees with The House Coordination Committee’s decision that the first resolve clause is covered by existing section of the Code of Ethics 2.1.1 Informed Consent. Additionally, we agree with testimony that the second resolve clause is covered by 4.2.1 Assisted Reproductive Technology and H-320.951. Your Reference Committee recommends reaffirmation of existing policy in lieu of Resolution 008.

2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patient’s authorization or agreement to undergo a specific medical intervention. In seeking a patient’s informed consent (or the consent of the patient’s surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient’s ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient’s preferences for receiving medical information. The physician should include information about:

(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient’s (or surrogate’s) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient’s surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.
AMA Principles of Medical Ethics: I,II,V,VIII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. Issued: 2016.

4.2.1 Assisted Reproductive Technology
Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

“Assisted reproductive technology” is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.
Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:
(a) Value the well-being of the patient and potential offspring as paramount.
(b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
(c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.
(d) Provide patients with psychological assessment, support and counseling or a referral to such services.
(e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
(f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.

(g) Participate in the development of peer-established guidelines and self-regulation.

**AMA Principles of Medical Ethics: I, V, VII**

*The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. Issued: 2016.*

**AMA Opposition to "Procedure-Specific" Informed Consent H-320.951**

Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure.


(76) **RESOLUTION 021 - SUPPORT FURTHER INTERVENTION IN CAREGIVER SUPPORT FOR END-OF-LIFE PATIENTS**

**RECOMMENDATION:**

*Policies H-160.919 and H-210.980 be reaffirmed in lieu of Resolution 021.*

RESOLVED, That the AMA encourage a standard common practice such as the three-step support model for caregiver support in the hospital, and encourage that continuity of care is maintained in end-of-life care; and

RESOLVED, That the AMA encourage the use of the currently validated BSFC to subsequently understand and address gaps in caregiver needs, especially utilizing social services and other hospital support programs to address gaps.

VRC testimony was opposed to the resolution as written. The Reference Committee agrees with the House Coordination Committee’s decision to place this resolution on the reaffirmation consent calendar. Your Reference Committee discussed the feasibility of both resolved clauses and noted that the resolution does not adequately address why the three-step support model should be a standard common practice - leaving it to be problematic in encouraging its use. The second resolve does not provide sufficient evidence to support the specific tool that the AMA is to encourage. Furthermore, these asks are already more broadly covered by existing policy. We agree with testimony that the first resolve is covered by 5.1 Advance Care Planning and H-160.919 while the second resolve clause is covered by H-210.980. Your Reference Committee
5.1 Advance Care Planning

The process of advance care planning is widely recognized as a way to support patient self-determination, facilitate decision making, and promote better care at the end of life. Although often thought of primarily for terminally ill patients or those with chronic medical conditions, advance care planning is valuable for everyone, regardless of age or current health status. Planning in advance for decisions about care in the event of a life-threatening illness or injury gives individuals the opportunity to reflect on and express the values they want to have govern their care, to articulate the factors that are important to them for quality of life, and to make clear any preferences they have with respect to specific interventions. Importantly, these discussions also give individuals the opportunity to identify who they would want to make decisions for them should they not have decision-making capacity.

Proactively discussing with patients what they would or would not want if recovery from illness or injury is improbable also gives physicians opportunity to address patients’ concerns and expectations and clarify misunderstandings individuals may have about specific medical conditions or interventions. Encouraging patients to share their views with their families or other intimates and record them in advance directives, and to name a surrogate decision maker, helps to ensure that patients’ own values, goals, and preferences will inform care decisions even when they cannot speak for themselves.

Physicians must recognize, however that patients and families approach decision making in many different ways, informed by culture, faith traditions, and life experience, and should be sensitive to each patient’s individual situations and preferences when broaching discussion of planning for care at the end of life.

Physicians should routinely engage their patients in advance care planning in keeping with the following guidelines:

(a) Regularly encourage all patients, regardless of age or health status, to:
(i) think about their values and perspectives on quality of life and articulate what goals they would have for care if they faced a life-threatening illness or injury, including any preferences they may have about specific medical interventions (such as pain management, medically administered nutrition and hydration, mechanical ventilation, use of antibiotics, dialysis, or cardiopulmonary resuscitation);
(ii) identify someone they would want to have make decisions on their behalf if they did not have decision-making capacity;
(iii) make their views known to their designated surrogate and to (other) family members or intimates.

(b) Be prepared to answer questions about advance care planning, to help patients formulate their views, and to help them articulate their preferences for care (including their wishes regarding time-limited trials of interventions and surrogate decision maker). Physicians should also be prepared to refer patients to additional resources for further information and guidance if appropriate.

(c) Explain how advance directives, as written articulations of patients’ preferences, are used as tools to help guide treatment decisions in collaboration with patients themselves when they have decision-making capacity, or with surrogates when they do not, and explain the surrogate’s responsibilities in decision making. Involve the patient’s surrogate in this conversation whenever possible.

(d) Incorporate notes from the advance care planning discussion into the medical record. Patient values, preferences for treatment, and designation of surrogate decision maker should be included in the notes to be used as guidance when the patient is unable to express his or her own decisions. If the patient has an advance directive document or written designation of proxy, include a copy (or note the existence of the directive) in the medical record and encourage the patient to give a copy to his or her surrogate and others to help ensure it will be available when needed.

(e) Periodically review with the patient his or her goals, preferences, and chosen decision maker, which often change over time or with changes in health status. Update the patient’s medical records accordingly when preferences have changed to ensure that these continue to reflect the individual’s current wishes. If applicable, assist the patient with updating his or her advance directive or designation of proxy forms. Involve the patient’s surrogate in these reviews whenever possible.

AMA Principles of Medical Ethics: I,IV
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. Issued: 2016

Principles of the Patient-Centered Medical Home H-160.919
1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home"
as follows:

Principles

Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:
Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making.
Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.
Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:
It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits.

(Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.

3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.

4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.

5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.

Physicians and Family Caregivers: Shared Responsibility H-210.980

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden; (2) continues to support health policies that facilitate and encourage health care in the home; (3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;
(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and
(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.
Res. 308, I-98; Reaffirmation A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17

(77) RESOLUTION 037 - GENDER PRONOUN USE IN MEDICAL EDUCATION

RECOMMENDATION:

Policies H-160.991, H-295.878, and 65.040MSS be reaffirmed in lieu of Resolution 037.

RESOLVED, That our AMA encourage physician leaders of healthcare teams to support pronoun education for all members of their teams; and it be further
RESOLVED, That our AMA promote utilization of gender pronouns on email signatures, name badges, and virtual communications; and it be further
RESOLVED, That our AMA research best practices for implementation of pronouns in medical education curriculum and reduction of incidents of misgendering; and it be further
RESOLVED, That our AMA supports the routine collection of data on the inclusion of gender pronoun use in medical school curricula.

VRC testimony was mixed. The Reference Committee agrees with testimony that the third and fourth resolve clauses are not feasible and are outside the AMA’s scope. The AMA is not a researching body, and asking for best practices and the routine collection of data is not an appropriate avenue to achieve the intent of this resolution. We agree with The House Coordination Committee’s decision that the first resolve clause is reaffirmation of pending transmittal 65.040MSS and that policies H-160.991 and H-295.878 cover the following resolves. Your Reference Committee recommends reaffirmation of existing policy in lieu of Resolution 037.

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
1. Our AMA: (a) believes that the physician’s nonjudgmental recognition of patients’ sexual orientations, sexual behaviors, and gender identities enhances the
ability to render optimal patient care in health as well as in illness. In the case of
lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ)
patients, this recognition is especially important to address the specific health care
needs of people who are or may be LGBTQ; (b) is committed to taking a leadership
role in: (i) educating physicians on the current state of research in and knowledge
of LGBTQ Health and the need to elicit relevant gender and sexuality information
from our patients; these efforts should start in medical school, but must also be a
part of continuing medical education; (ii) educating physicians to recognize the
physical and psychological needs of LGBTQ patients; (iii) encouraging the
development of educational programs in LGBTQ Health; (iv) encouraging
physicians to seek out local or national experts in the health care needs of LGBTQ
people so that all physicians will achieve a better understanding of the medical
needs of these populations; and (v) working with LGBTQ communities to offer
physicians the opportunity to better understand the medical needs of LGBTQ
patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual
orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians
regarding: (i) the need for sexual and gender minority individuals to undergo
regular cancer and sexually transmitted infection screenings based on anatomy
due to their comparable or elevated risk for these conditions; and (ii) the need for
comprehensive screening for sexually transmitted diseases in men who have sex
with men; (iii) appropriate safe sex techniques to avoid the risk for sexually
transmitted diseases; and (iv) that individuals who identify as a sexual and/or
gender minority (lesbian, gay, bisexual, transgender, queer/questioning
individuals) experience intimate partner violence, and how sexual and gender
minorities present with intimate partner violence differs from their cisgender,
heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including
GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other
organizations, focusing on issues of mutual concern in order to provide the most
comprehensive and up-to-date education and information to enable the provision
of high quality and culturally competent care to LGBTQ people.

9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17;
Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

Eliminating Health Disparities - Promoting Awareness and Education of
Sexual Orientation and Gender Identity Health Issues in Medical Education
H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups
and meet on-site to further their medical education or enhance patient care without
regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.

Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19

Supporting the Use of Gender-Neutral Language: 65.040MSS
Our AMA-MSS will ask our AMA to: (1) Recognize the importance of using gender-neutral language such as genderneutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity, (2) revise all relevant policies to utilize gender-neutral language in place of gendered language where such text inappropriately appears, (3) utilize gender-neutral language in future policies, internal communications, and external communications where gendered language does not specifically need to be used, (4) encourage the use of gender-neutral language in public health and medical messaging, (5) encourage other professional societies to utilize gender-neutral language in their work, and (6) support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals (MSS Res. 018, Nov. 2020) (MSS Res. 015, A-22, Adopt as Amended with Title Change)

(78) RESOLUTION 041 - SUPPORTING RESEARCH INTO HEAT RESPONSE PLANS

RECOMMENDATION:


RESOLVED, That our AMA work with relevant stakeholders to support further research on the evaluation of heat response plans, including mitigation and adaptation strategies; and be it further

RESOLVED, That our AMA supports the dissemination of pertinent education materials within healthcare facilities, including but not limited to upcoming heat waves, protective measures, and locations of local cooling centers.
VRC testimony was supportive of the resolution’s spirit. The Reference Committee agrees with the House Coordination Committee’s decision to place this resolution on the reaffirmation consent calendar. These policies extensively discuss climate change and building public health infrastructure. In this already-extant policies, particular attention is given to heat waves and patient education regarding emergency response. Your Reference Committee recommends policies H-135.938, H-135.938, and H-130.951 be reaffirmed in lieu of Resolution 041.

Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change’s fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the potential 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 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; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public 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 the AMA’s Center for Public Health Preparedness and Disaster Response assist in this effort.


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.
Global Climate Change and Human Health H-135.938

Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change’s fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the potential 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 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; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public 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 the AMA’s Center for Public Health Preparedness and Disaster Response assist in this effort.


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.

Heat-Related Illness H-130.951

The AMA recognizes the significant public health threat imposed by heat-related emergencies, and provides the following policy: (1) Physicians should identify patients at risk for extreme heat-related illness such as the elderly, children, individuals with physical or mental disabilities, alcoholics, the chronically ill, and the socially isolated. Patients, family members, friends, and caretakers should be counseled about prevention strategies to avoid such illness. Physicians should provide patients at risk with information about cooling centers and encourage
their use during heat emergencies. (2) The AMA encourages patients at risk for heat-related illness to consider wearing appropriate medical identification.

(79) RESOLUTION 050 - WASTE RECEPTACLES IN ALL RESTROOM STALLS FOR MENSTRUAL PRODUCT DISPOSAL

RECOMMENDATION:

Policy H-65.964 be reaffirmed in lieu of Resolution 050.

RESOLVED, That our AMA amend H-65.964 “Access to Basic Human Services for Transgender Individuals” as follows:

Access to Basic Human Services for Transgender Individuals H-65.964

1. Our AMA (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one’s gender identity, including the addition of waste receptacles in men’s restroom stalls for safe and discreet disposal of used menstrual products by transgender men and non-binary people.

VRC testimony was supportive of the resolution’s spirit. The Reference Committee agrees with the House Coordination Committee’s decision to place this resolution on the reaffirmation consent calendar. We believe further action can be taken by submitting the resolution as a MSSAI. Your Reference Committee recommends policy H-65.964 be reaffirmed in lieu of Resolution 050.

Access to Basic Human Services for Transgender Individuals H-65.964

1. Our AMA (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one’s gender identity.

(80) RESOLUTION 065 - EXPANDING MEDICAL NUTRITION THERAPY COVERAGE IN MEDICARE AND MEDICAID PLANS

RECOMMENDATION:

Policy H-150.931 be reaffirmed in lieu of Resolution 065.
RESOLVED, Our AMA advocates for expansion of Medicare and Medicaid plans to include all medical nutrition therapy services deemed necessary by a physician referral in the treatment of chronic disease.

VRC testimony was mixed. The Reference Committee agrees with testimony that the ask of this resolution is no different from existing policy. Nutrition support teams include those with a background in MNT. Payment for provision of services encompasses the public payment suggested in the whereas clause. This policy may be better advocated for by an MSS Action Item. Your Reference Committee recommends policy H-150.931 be reaffirmed in lieu of Resolution 065.

**Payment for Nutrition Support Services H-150.931**

Our AMA recognizes the value of nutrition support teams services and their role in positive patient outcomes and supports payment for the provision of their services.

(81) RESOLUTION 066 - INCREASED REGULATION OF COMMERCIAL ELECTRIC SCOOTER USE

**RECOMMENDATION:**

**Policies H-15.960, H-10.964, and H-30.936 be reaffirmed in lieu of Resolution 066.**

RESOLVED, Our AMA collaborate with state and local medical societies to advocate for regulations against the use of commercial electric scooters while under the influence and without proper protective gear to reduce commercial electric scooter-related injury and death.

VRC testimony was opposed to the resolution as written. The Reference Committee agrees with the House Coordination Committee’s decision to place this resolution on the reaffirmation consent calendar. We agree with testimony that electric/motorized scooters are considered vehicles and are thus covered by regional laws regarding use while under the influence. We also agree that regulatory efforts to enforce protective gear are not likely to be implemented, but promoting enforcement of these laws may unintentionally and disproportionately impact marginalized groups. Your Reference Committee recommends policies H-15.960, H-10.964, and H-30.936 be reaffirmed in lieu of Resolution 066.

**Motor Vehicle and Bicycle Safety H-15.960**

The AMA supports legislation that would make safety belt non-use by any occupants in automobiles and other enclosed motor vehicles a "primary offense"
in all states; supports extension of motorcycle helmet laws to include motorized
vehicles such as mopeds, scooters and all-terrain vehicles, and to cover all age
groups; and supports legislation that would require helmet usage for riders of
bicycles, including passengers.
Res. 226, A-95; Reaffirmed: BOT Rep. 12, A-05; Reaffirmed: CSAPH Rep. 1, A-

Helmets for Riders of Motorized and Non-motorized Cycles H-10.964
General Helmet Use: Our AMA: (1) encourages physicians to counsel their
patients who ride motorized and non-motorized cycles to use approved helmets
and appropriate protective clothing while cycling; (2) encourages patients and
families to inform and train children about safe cycle-riding procedures,
especially on roads and at intersections, the need to obey traffic laws, and the
need for responsible behavior; (3) encourages community agencies, such as
those involving law enforcement, schools, and parent-teacher organizations, to
promote training programs for the responsible use of cycles; (4) urges
manufacturers to improve the safety and reliability of the vehicles they produce
and to support measures to improve cycling safety; (5) advocates further
research on the effectiveness of helmets and on the health outcomes of
community programs that mandate their use; (6) encourages efforts to
investigate the impact of helmet use by riders of motorcycles and all bicycles, in
order to establish the risk of major medical trauma from not wearing helmets, the
costs added to the health care system by such behavior, and the payers of these
added costs (i.e., private insurance, uncompensated care, Medicare, Medicaid,
etc.); (7) supports the exploration of ways to ensure the wearing of helmets
through the use of disincentives or incentives such as licensing fees, insurance
premium adjustments and other payment possibilities.
Bicycles: Our AMA: (1) actively supports bicycle helmet use and encourages
physicians to educate their patients about the importance of bicycle helmet use;
(2) encourages the manufacture, distribution, and utilization of safe, effective,
and reasonably priced bicycle helmets; and (3) encourages the availability of
helmets at the point of bicycle purchase.
Scooters: Our AMA: (1) recommends the use of protective gear (certified
helmets, elbow and knee pads, closed-toe shoes) for riders of scooters,
especially children and adolescents; (2) encourages physicians to counsel
patients, and their parents when appropriate, that full protective equipment
should be worn and appropriate safety measures should be taken to prevent
scooter injuries (e.g., riding away from traffic, and close supervision of riders
under the age of eight); and (3) urges companies that manufacture or sell
scooters to include appropriate information about the safe use of scooters on the
scooters themselves, on or inside scooter packaging, on their web sites, and at
the point of sale.
Motorcycles: Our AMA: (1) encourages physicians to be aware of motorcycle
risks and safety measures and to counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs; (2) endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (3) supports federal regulatory rules to make the receipt of federal highway funds by a state dependent on passage of mandatory motorcycle helmet laws by that state; (4) urges constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (5) supports rider education legislation, which is more easily implemented and more effective than legislation requiring manufacturers to emphasize the dangers of operating motorcycles.

Prevention of Impaired Driving H-30.936

Our AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks; (2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; and (3) supports 21 as the legal drinking age, strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21.

Education: Our AMA: (1) favors public information and education against any drinking by drivers; (2) supports efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (3) encourages physicians to participate in educating patients and the public about the hazards of chemically impaired driving; (4) urges public education messages that now use the phrase "drunk driving," or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that "all alcohol use, even at low levels, impairs driving performance and poses significant health and safety risks;" (5) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents; and (6) supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will continue to work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve those goals.

Legislation: Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties
when a driver under age 21 drives with any blood alcohol level (except for
minimal blood alcohol levels, such as less than .02 percent, only from
medications or religious practices): (a) for the first offense - mandatory revocation
of the driver's license for one year and (b) for the second offense - mandatory
revocation of the driver's license for two years or until age 21, whichever is
greater; (2) urges state medical associations to seek enactment of the legislation
in their legislatures; (3) urges all states to pass legislation mandating all drivers
convicted of first and multiple DUI offenses be screened for alcoholism and
provided with referral and treatment when indicated; (4) urges adoption by all
states of legislation calling for administrative suspension or revocation of driver
licenses after conviction for driving under the influence, and mandatory
revocation after a specified number of repeat offenses; and (5) encourages
passage of state traffic safety legislation that mandates screening for substance
use disorder for all DUI offenders, with those who are identified with substance
use disorder being strongly encouraged and assisted in obtaining treatment from
qualified physicians and through state and medically certified facilities.

Treatment: Our AMA: (1) encourages that treatment of all convicted DUI
offenders, when medically indicated, be mandated and provided but in the case
of first-time DUI convictions, should not replace other sanctions which courts may
levy in such a way as to remove from the record the occurrence of that offense;
and (2) encourages that treatment of repeat DUI offenders, when medically
indicated, be mandated and provided but should not replace other sanctions
which courts may levy. In all cases where treatment is provided to a DUI
offender, it is also recommended that appropriate adjunct services should be
provided to or encouraged among the family members actively involved in the
offender's life;

Repeat Offenders: Our AMA: (1) recommends the following measures be taken
to reduce repeat DUI offenses: (a) aggressive measures be applied to first-time
DUI offenders (e.g., license suspension and administrative license revocation),
(b) stronger penalties be leveled against repeat offenders, including second-time
offenders, (c) such legal sanctions must be linked, for all offenders, to substance
abuse assessment and treatment services, to prevent future deaths in alcohol-
related crashes and multiple DUI offenses; and (2) calls upon the states to
coordinate law enforcement, court system, and motor vehicle departments to
implement forceful and swift penalties for second-time DUI convictions to send
the message that those who drink and drive might receive a second chance but
not a third.

On-board devices: Our AMA: (1) supports further testing of on-board devices to
prevent the use of motor vehicles by intoxicated drivers; this testing should take
place among the general population of drivers, as well as among drivers having
alcohol-related problems; (2) encourages motor vehicle manufacturers and the
U.S. Department of Transportation to monitor the development of ignition
interlock technology, and plan for use of such systems by the general population,
when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and safe; and (3) supports continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender's family members.

(82) RESOLUTION 069 - ENABLING TRANSMISSION OF THIRD-PARTY DATA AND METADATA TO ELECTRONIC HEALTH RECORDS

RECOMMENDATION:


RESOLVED, That AMA policy H-478.981 be amended by addition and deletion as follows:

Health Information Technology Principles H-478.981

Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:

1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data and metadata (i.e. information about the source of the data) liquidity;
7. Include write capability;
8. Facilitate digital and mobile patient engagement; and
9. Expedite user input into product design and post-implementation feedback.

Our AMA will utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of “Information Blocking”; and
7. Promote the inclusion of write capability in all EHRs"
Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

VRC testimony was opposed to the resolution as written. The Reference Committee agrees with the House Coordination Committee’s decision to place this resolution on the reaffirmation consent calendar. Your Reference Committee recommends policies D-478.972, H-480.953, and D-478.996 be reaffirmed in lieu of Resolution 069.

**EHR Interoperability D-478.972**

Our AMA:

1. will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
2. supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
3. will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
4. will continue efforts to promote interoperability of EHRs and clinical registries;
5. will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
6. will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
7. will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
8. will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
9. will review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.

**Interoperability of Medical Devices H-480.953**
Our AMA believes that intercommunication and interoperability of electronic medical devices could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. Our AMA also recognizes that, as in all technological advances, interoperability poses safety and medico-legal challenges as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve optimum patient safety, efficiency, and outcome benefit while preserving incentives to ensure continuing innovation.

**Information Technology Standards and Costs D-478.996**

1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards.

**(83)** RESOLUTION 070 - SCHOOL BASED MENTAL HEALTH PROGRAMS FOR CHILDREN EXPOSED TO GUN VIOLENCE

**RECOMMENDATION:**

Policies H-345.977, H-515.952, and H-60.929 be reaffirmed in lieu of Resolution 070.

RESOLVED, that our AMA amend “Improving Pediatric Mental Health Screening”, H-345.977 by the addition as follows:
Improving Pediatric Mental Health Screening, H-345.977

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents (including those exposed to and affected by gun violence) access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

RESOLVED, That our AMA endorses research into the impact of school-based mental health interventions on long-term health and behavioral outcomes in children.

VRC testimony was supportive of reaffirmation. The Reference Committee agrees with testimony that the amendments to the first resolve clause are not novel and do not significantly change the meaning of existing policy. Additionally, we believe that the second resolve clause is reaffirmation of existing policy, as AMA policy already endorses school-based mental health programs and has indicated there is sufficient research that they are effective. Your Reference Committee recommends policies H-345.977, H-515.952, and H-60.929 be reaffirmed in lieu of Resolution 070.

Improving Pediatric Mental Health Screening H-345.977

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

Adverse Childhood Experiences and Trauma-Informed Care H-515.952

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

3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.

National Child Traumatic Stress Network H-60.929
Our AMA: (1) recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by the National Child Traumatic Stress Initiative; and (2) will work with mental health organizations and relevant health care organizations to support full funding of the National Child Traumatic Stress Initiative.

(84) RESOLUTION 073 - DECREASING THE BURDEN OF OUT-OF-POCKET COSTS FOR BIOLOGIC THERAPIES

RECOMMENDATION:

Policies H-125.976 and H-125.980 be reaffirmed in lieu of Resolution 073.

RESOLVED, Our AMA advocates for policy on price capping for pharmaceutical/prescription drug insurance plans alongside Medicare Part D.

RESOLVED, Our AMA encourages expansion of both patient and physician education programs to increase awareness and understanding of biosimilars that exist in the U.S. and advocate for the development of patient assistance programs for biologics that do not have biosimilar or interchangeable biosimilar alternatives.
RESOLVED, Our AMA encourages expansion of research for interchangeable biosimilar, generic alternatives identical to current biologics on the market, and biosimilars.

VRC testimony was opposed to the resolution as written. The Reference Committee agrees with testimony that the first resolve clause lacks clarity, as to whether it is capping drug price or out-of-pocket expenses, and an objective. As mentioned in VRC testimony, out-of-pocket expense maximums have been extensively covered in current legislation, including the Affordable Care Act of 2010. We agree with the House Coordinate Committee’s decision to place the third resolve clause on the reaffirmation calendar due to existing policies H-125.976 and H-125.980 which support interchangeability and research/approval of biosimilar medications. We believe that the asks of the second resolve are insufficient in mitigating cost burden, however your Reference Committee found that current policies broadly cover these asks. Your Reference Committee recommends policies H-125.976 and H-125.980 be reaffirmed in lieu of Resolution 073.

**Biosimilar Interchangeability Pathway H-125.976**

Our AMA will: (1) strongly support the pathway for demonstrating biosimilar interchangeability that was proposed in draft guidance by the FDA in 2017, including requiring manufacturers to use studies to determine whether alternating between a reference product and the proposed interchangeable biosimilar multiple times impacts the safety or efficacy of the drug; and (2) issue a request to the FDA that the agency finalize the biosimilars interchangeability pathway outlined in its draft guidance “Considerations in Demonstrating Interchangeability With a Reference Product” with all due haste, so as to allow development and designation of interchangeable biosimilars to proceed, allowing transition to an era of less expensive biologics that provide safe, effective, and accessible treatment options for patients. Res. 523, A-18

**Abbreviated Pathway for Biosimilar Approval H-125.980**

Our AMA supports FDA implementation of the Biologics Price Competition and Innovation Act of 2009 in a manner that 1) places appropriate emphasis on promoting patient access, protecting patient safety, and preserving market competition and innovation; 2) includes planning by the FDA and the allocation of sufficient resources to ensure that physicians understand the distinctions between biosimilar products that are considered highly similar, and those that are deemed interchangeable. Focused educational activities must precede and accompany the entry of biosimilars into the U.S. market, both for physicians and patients; and 3) includes compiling and maintaining an official compendium of biosimilar products, biologic reference products, and their related interchangeable biosimilars as they are developed and approved for marketing by the FDA.

RESOLUTION 075 - MITIGATING BARRIERS FACED BY MUSLIM HEALTHCARE WORKERS

RECOMMENDATION:

Policy H-65.965 be reaffirmed in lieu of Resolution 075.

RESOLVED, That our AMA support:

1. Work and school accommodations made for religious obligations, including prayer and fasting
2. Inclusion of Islamophobia awareness and prevention in diversity and inclusion programming
3. Systematic solutions to mitigate instances of discrimination faced in receiving career-advancing opportunities, or by patients and colleagues in the healthcare setting
4. Methods to mitigate instances of violence and hate crimes directed towards Muslim healthcare workers

VRC testimony was in support of reaffirmation and the spirit of the resolution. While the Reference Committee supports the spirit of this resolution, we agree with the House Coordination Committee’s decision to place this resolution on the reaffirmation consent calendar. VRC testimony mentioned several policies that cover the asks, including resolve one covered by H-310.923 and 9.5.4 Civil Rights & Medical Professionals, resolve two covered by H-65.951 and Discrimination. B-1.4, resolve three covered by 9.5.4 Civil Rights & Medical Professionals and resolve four covered by H-515.951. We agree with this testimony of several existing policies that encompass these asks of religious freedom and opposing discrimination. Your Reference Committee recommends policy H-65.965 be reaffirmed in lieu of Resolution 075.

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual’s sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual’s sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA’s policy through letters to members of Congress; and
registers support for hate crimes prevention legislation, via letter, to the President of the United States.

(86) RESOLUTION 076 - EMPHASIZING AND EXPANDING SUN PROTECTION LESSONS IN K-12 CHILDREN

RECOMMENDATION:

Policy H-440.839 be reaffirmed in lieu of Resolution 076.

RESOLVED, that our American Medical Association to amend policy MSS 60.011 “Sun Protection Programs and Education in K-12 Schools,” by addition to read as follows:

“AMA-MSS will support working with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Dermatology and other appropriate entities to encourage schools, after-school programs, community centers, and fitness facilities to incorporate sun protection policies and annual sun safety education, including the disparity of skin cancer prognosis in people with skin of color”

VRC testimony was limited and in support of reaffirmation. The Reference Committee agrees with the House Coordination Committee’s decision to place this resolution on the reaffirmation consent calendar. We agree with testimony that this resolution would not significantly impact AMA’s advocacy efforts with the addition of a few stakeholders and may be out of the AMA’s scope. Your Reference Committee recommends policy H-440.839 be reaffirmed in lieu of Resolution 076.

Protecting the Public from Dangers of Ultraviolet Radiation H-440.839

1. Our AMA encourages physicians to counsel their patients on sun-protective behavior.

TANNING PARLORS: Our AMA supports: (a) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (b) legislation to strengthen state laws to make the consumer as informed and safe as possible; (c) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (d) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (e) the enactment of federal legislation to: (i) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR 1040.20 [a][9]) by anyone under the age of 18; and (ii) require a United States Surgeon General warning be prominently posted, detailing the positive
correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (f) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (g) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (h) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (i) intensified efforts to enforce current regulations.

SUNSCREENS. Our AMA supports: (a) the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (b) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level.

2. Our AMA supports sun shade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical important of sun protection as a public health measure.

3. Our AMA, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (a) provide sunscreen that is SPF 15 or higher and broad spectrum; (b) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (c) protect the product from excessive heat and direct sun.

(87) RESOLUTION 077 - AMENDING EXISTING PREVENTATIVE POLICY TO DECREASE COMORBIDITIES IN PATIENTS WITH DEVELOPMENTAL DISABILITIES

RECOMMENDATION:

Policies H-90.968, H-60.974, and H-90.971 be reaffirmed in lieu of Resolution 077.

RESOLVED, That our AMA amend H-425.987, “Preventive Medicine Services”, by addition as follows:

Preventive Medicine Services, H-425.987
1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) working with relevant stakeholders to promote communication and practice styles that apply to patients with developmental delays; (BC) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (CD) appropriate reimbursement and coding for established preventive services.

2. Our AMA will seek legislation or regulation so that evidence-based screenings are paid for separately when provided as part of a comprehensive well-patient examination/review.

RESOLVED, That our AMA amend H-460.894, “Value of Preventive Services”, by addition as follows:

Value of Preventive Services, H-460.894
Our AMA: (1) encourages committees that make preventive services recommendations to: (a) follow processes that promote transparency and clarity among their methods; (b) develop evidence reviews and recommendations with enough specificity to inform cost-effectiveness analyses; (c) rely on the very best evidence available, with consideration of expert consensus only when other evidence is not available; (d) work together to identify preventive services that are not supported by evidence or are not cost-effective, with the goal of prioritizing preventive services; and (e) consider the development of recommendations on both primary and secondary prevention; and (f) advocate the position that preventive services are inclusive to all patient populations in order to decrease avoidable healthcare disparities; (2) encourages relevant national medical specialty societies to provide input during the preventive services recommendation development process; (3) encourages comparative-effectiveness research on secondary prevention to provide data that could support evidence-based decision making; and (4) encourages public and private payers to cover preventive services for which consensus has emerged in the recommendations of multiple guidelines-making groups.

VRC testimony was in support of reaffirmation. The Reference Committee agrees with the House Coordination Committee’s decision to place this resolution on the reaffirmation consent calendar. We agree with testimony that the proposed amendments will not change AMA’s advocacy. The AMA already has policies that support efforts to improve care delivery to people with disabilities and affirm the importance of preventive services. Your Reference Committee recommends policies H-90.968, H-60.974, and H-90.971 be reaffirmed in lieu of Resolution 077.

Medical Care of Persons with Disabilities H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.

2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.

3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles: (a) All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual’s medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.

4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.

5. Our AMA recognizes the importance of managing the health of children and
adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.

6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.

7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.

8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.

9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.

10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.

11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages: (a) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education; (b) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities; and (c) cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

Children and Youth With Disabilities H-60.974

It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities; (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted; (3) to encourage physicians to provide services to children and youth with disabilities that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child; (4) to encourage physicians to provide schools with medical information to ensure
that children and youth with disabilities receive appropriate school health services; 
(5) to encourage physicians to establish formal transition programs or activities 
that help adolescents with disabilities and their families to plan and make the 
transition to the adult medical care system; 
(6) to inform physicians of available educational and other local resources, as well 
as various manuals that would help prepare them to provide family-centered health 
care; and 
(7) to encourage physicians to make their offices accessible to patients with 
disabilities, especially when doing office construction and renovations.

Reaffirmed: CSAPH Rep. 1, A-21

Enhancing Accommodations for People with Disabilities H-90.971
Our AMA encourages physicians to make their offices accessible to patients with 
disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines. 
Res. 705, A-13

(88) RESOLUTION 082 - AMENDMENT TO AMA POLICY SHARING OF MEDICAL 
DISCIPLINARY DATA AMONG NATIONS D-275.975

RECOMMENDATION:

Policies D-478.981 and H-315.973 be reaffirmed in lieu of Resolution 082.

RESOLVED, That AMA policy D-275.975, “Sharing of Medical Disciplinary Data Among 
Nations” be amended by addition and deletion as follows:

Sharing of Medical Disciplinary Health Data Among Nations D-275.975
1. Our AMA will, in conjunction with the Federation of State Medical Boards, 
support the efforts of the International Association of Medical Regulatory 
Authorities in its current efforts toward the exchange of health information among 
medical regulatory authorities worldwide.
2. Our AMA support further initiatives and funding into developing guidelines for 
international and intersectoral sharing of preclinical and clinical health data that 
advance scientific and medical research to improve patient care.

VRC testimony was mixed. The Reference Committee agrees with the House 
Coordination Committee’s decision to place this resolution on the reaffirmation consent 
calendar. In addition to existing HOD policy, this resolution is also covered by B-6.4 and 
460.017MSS. Your Reference Committee recommends policies D-478.981 and H-
315.973 be reaffirmed in lieu of Resolution 082.
Exchange of Electronic Data Among Clinicians, Public Health Entities and Research Entities D-478.981

Our AMA will proactively work with the Department of Health and Human Services and appropriate public health and research entities to develop ways to facilitate, as much as possible, seamless, properly regulated, electronic exchange of data generated in the health care setting, including the development of open standards for such data exchange, provided that such technology has intrinsic systems that include the protection of individually identifiable health information that is acceptable to patients, to the extent that law permits.

Res. 827, I-10; Reaffirmation I-13

Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data H-315.973

1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles:
   a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose.
   b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules.
   c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used.
   d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data.
   e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities.
   f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed.
   g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data.
   h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations.

2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles:
   a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims
data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information.

b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.

c. Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified.

d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.

CMS Rep. 6, I-06; Reaffirmed: BOT Rep. 17, A-13

Council on Science and Public Health. B-6.4

6.4.1 Functions

6.4.1.1 To advise on substantial and promising developments in the scientific aspects of medicine, public health, and biomedical research that warrant public attention;

6.4.1.2 To advise on professional and public information activities that might be undertaken by the AMA in the fields of scientific medicine and public health;

6.4.1.3 To assist in the preparation of policy positions on scientific issues in medicine and public health raised by the public media;

6.4.1.4 To advise on policy positions on aspects of government support, involvement in, or control of biomedical and public health research;

6.4.1.5 To advise on opportunities to coordinate or cooperate with national medical specialty societies, voluntary health agencies, other professional organizations and governmental agencies on scientific activities in medicine and public health;

6.4.1.6 To consider and evaluate the benefits that might be derived from joint development of domestic and international programs on scientific issues in medicine and public health; and

6.4.1.7 To propose and evaluate activities that might be undertaken by the AMA as major scientific projects in medicine or public health, either individually or jointly with state associations and component societies.

6.4.2 Membership.

6.4.2.1 Twelve active members of the AMA, one of whom shall be a resident/fellow physician, and one of whom shall be a medical student.

(89) RESOLUTION 084 - COMBATING ANTIMICROBIAL RESISTANCE THROUGH ETHNOPHARMACOLOGY

RECOMMENDATION:
Policy H-100.973 be reaffirmed in lieu of Resolution 084.

RESOLVED, that our American Medical Association to amend policy H-100.973, “Combating Antimicrobial Resistance through Education,” by addition to read as follows:

**Combating Antimicrobial Resistance through Education H-100.973**

Our AMA: (1) encourages the federal government, the World Health Organization, the World Medical Association, and the International Federation of Pharmacists to promote more effective education concerning the appropriate use of antibiotics;

(2) strongly urges physicians to educate their patients about their antimicrobial therapy, the importance of compliance with the prescribed regimen, and the problem of antimicrobial resistance;

(3) will continue to educate physicians and physicians-in-training about the appropriate prescribing of antimicrobial agents;

(4) encourages the use of antibiotic resistance management programs; these education-based programs should be multidisciplinary and cooperative (i.e., including infectious disease physicians, infection-control specialists, microbiology laboratory personnel, and clinical pharmacists);

(5) encourages continued scientific research on the issue of antibiotic resistance; including the efficacy and safety of ethnopharmacologic agents that work independently from and synergistically with current antibiotics.

VRC testimony was in support of reaffirmation. The Reference Committee agrees with the House Coordination Committee’s decision to place this resolution on the reaffirmation consent calendar; existing policy broadly covers the asks of this resolution. Your Reference Committee recommends policy H-100.973 be reaffirmed in lieu of Resolution 084.

**Combating Antimicrobial Resistance through Education H-100.973**

Our AMA: (1) encourages the federal government, the World Health Organization, the World Medical Association, and the International Federation of Pharmacists to promote more effective education concerning the appropriate use of antibiotics;

(2) strongly urges physicians to educate their patients about their antimicrobial therapy, the importance of compliance with the prescribed regimen, and the problem of antimicrobial resistance;

(3) will continue to educate physicians and physicians-in-training about the appropriate prescribing of antimicrobial agents;

(4) encourages the use of antibiotic resistance management programs; these education-based programs should be multidisciplinary and cooperative (i.e., including infectious disease physicians, infection-control specialists, microbiology laboratory personnel, and clinical pharmacists);
laboratory personnel, and clinical pharmacists); and
(5) encourages continued scientific research on the issue of antibiotic resistance.
Reaffirmation I-98; Modified: CSA Rep. 3, A-00; Reaffirmation I-07; Reaffirmed:
CSAPH Rep. 3, I-15