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

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

| **Cmte\*** | **Item** | **Sponsor†** | **Title** | **Recommendations or Resolves** |
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| .Con | BOT 05 | n/a | Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment | In keeping with these considerations, your Board of Trustees recommends that G-600.067, “Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment,” be rescinded, the following be adopted, and the remainder of this report be filed:That our AMA recommend preferred terminology for protected personal characteristics to be used in AMA policies and position statements. (Directive to Take Action) |
| .Con | BOT 11 | n/a | National Guidelines for Guardianship | 1. That Opinion 8.10, “Preventing, Identifying and Treating Violence and Abuse;” H-515.961, “Elder Mistreatment;” and H-515-984, “Health Care Costs of Violence and Abuse Across the Lifespan,” be reaffirmed. (Reaffirm HOD Policy)
2. That our AMA support initiatives by the American Bar Association Commission on Law and Aging and other associations and agencies of the federal government to address elder abuse and to ensure consistent protection of elders’ rights in all states. (Directive to Take Action)
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| .Con | BOT 13 | n/a | Study of Forced Organ Harvesting by China | 1. That our American Medical Association continue to engage the Chinese Medical Association and the transplant community in the People’s Republic of China (PRC) through promotion and support of relevant activities and policies of the World Medical Association that relate to organ transplantation. (Directive to Take Action)
2. That our AMA, through its membership in the World Medical Association, continue to call for the PRC’s compliance with internationally recognized organ transplantation standards, such as those of the World Health Organization, and for the PRC to make available externally verifiable data on organ transplantation. (Directive to Take Action)
3. That our AMA condemn the retrieval of organs for transplantation without the informed consent of the donor. (New HOD Policy)
4. That Policy D-370.981, “Study of Forced Organ Harvesting by China,” be rescinded, having been accomplished by this report. (Rescind HOD Policy)
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| .Con | BOT 15 | n/a | Opposing Attorney Presence at and/or Recording of Independent Medical Examinations | That, upon request of state medical associations and national medical specialty societies, our AMA will provide assistance and consultation in opposing the ability of courts to compel recording and videotaping of, or allow a court reporter or an attorney to be present during the independent medical examination, as a condition precedent to allowing the physician’s medical opinion in court. (Directive to Take Action) |
| .Con | BOT 16 | n/a | Research Handling of De-Identified Patient Information | 1. That our American Medical Association (AMA) reaffirm Policies H-315.975, “Police, Payer, and Government Access to Patient Health Information,” H-315.978, “Privacy and Confidentiality,” and H‑315.987, “Limiting Access to Medical Records.” (Reaffirm HOD Policy)
2. That our AMA adopt a technical change to Policy H-315.974, “Guiding Principles, Collection and Warehousing of Electronic Medical Record Information,” by addition as follows: (Modify Current HOD Policy)

Policy H-315.974, “Guiding Principles, Collection and Warehousing of Electronic Medical Record Information”Our AMA expressly advocates for physician ownership of all claims data, transactional data and de-identified and/or aggregate data created, established and maintained by a physician practice, regardless of how and where such data is stored but specifically including any such data derived from a physician's medical records, electronic health records, or practice management system, while preserving the principle that physicians act as trusted stewards of Protected Health Information.1. That our AMA support efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information. (New HOD Policy)
2. That our Council on Ethical and Judicial Affairs consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data. (Directive to Take Action)
3. That Policy D-315.975, “Research Handling of De-Identified Patient Information,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)
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| .Con | BOT 20 | n/a | Specialty Society Representation in the House of Delegates Five-Year Review | The Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:1. That the American Academy of Insurance Medicine, American Academy of Sleep Medicine, American Society of Gastrointestinal Endoscopy, American Urological Association, American Society of Plastic Surgeons, AMSUS The Society of Federal Health Professionals and North American Spine Society retain representation in the American Medical Association House of Delegates. (Directive to Take Action)
2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, American Society of Radiation Oncology, American Society for Surgery of the Hand, Society for Vascular Surgery, and the Society of American Gastrointestinal and Endoscopic Surgeons be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year’s grace period to increase membership, the American Society of Abdominal Surgeons and the International Association of Independent Medical Evaluators not retain representation in the House of Delegates. (Directive to Take Action)
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| .Con | CCB 01 | n/a | Further Action on Bylaw 7.5.2 | The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting. 7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.7.5.1 Membership. All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section until December 31 of the year of their 40th birthday or December 31 of the eighth year following completion of their graduate medical education, whichever comes last.7.5.2 Cessation of Eligibility of Governing Council Members. If any Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If any member’s term would terminate prior to the conclusion of an Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting ~~in the calendar year~~ following that when such member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the member remains an active physician member of the AMA.7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 when elected as chair-elect. The chair-elect, chair and immediate past chair shall be granted membership in the Section and be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA. |
| .Con | CCB 02 | n/a | Rescission of Bylaws Related to Run-off Elections | The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.\*\*\*~~3.4.2.2~~ ~~At-Large Trustees to be Elected to Fill Vacancies after a Prior Ballot. The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4-year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.~~[Subsequent bylaw provisions will be renumbered accordingly.]\*\*\*\*6.8 Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.\*\*\*~~6.8.1.5~~ ~~Council Members to be Elected to Fill Vacancies after a Prior Ballot. The nomination and election of members of the Council to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other members of the Council, and shall follow the same procedure. Individuals elected to such vacancy shall be elected to a complete 4-year term. Unsuccessful candidates in the election for members of the Council shall automatically be nominated for subsequent elections to fill any such vacancy until all members of the Council have been elected. In addition, nominations from the floor shall be accepted.~~ |
| .Con | CCB 03 | n/a | AMA Women Physicians Section: Clarification of Bylaw Language | The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.7.10 Women Physicians Section. The Women Physicians Section is a delineated Section.7.10.1 Membership. All female physicians and female medical students who are active members of the AMA shall be ~~eligible to be~~ members of the Women Physicians Section. ~~7.10.1.1~~ Other active members of the AMA who express an interest in women’s issues may also ~~shall be eligible to~~ join the section. |
| .Con | CEJA 01 | n/a | Short-term Medical Service Trips | Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have emerged as a prominent response for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.By definition, short-term medical service trips take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities to enable good health outcomes, promote justice and sustainability, minimize burdens on host communities, and respect persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of sponsors and participants in collaboration with host communities.Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:(a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should identify opportunities for and priority of efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team.(b) Seek to proactively identify and minimize burdens the trip may place on the host community, including not only direct, material costs of hosting volunteers, but on possible disruptive effects the presence of volunteers could have for local practice and practitioners as well. Sponsors and participants should ensure that team members practice only within their skill sets and experience, and that resources are available to support the success of the trip, including arranging for local mentors, translation services, and volunteers’ personal health needs as appropriate.(c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources to begin to cultivate the “cultural sensitivity” they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.Sponsors of short-term medical service trips should:(d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally.(e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, including the training, experience, and oversight of team members required to provide acceptable safe, high-quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with the professional standards of the sponsor’s country.(f) Put in place a mechanism to collect data on success in meeting collaboratively defined goals for the trip in keeping with recognized standards for the conduct of health services research and quality improvement activities in the sponsor’s country. |
| .Con | CEJA 02 | n/a | Amendments to Opinions 1.2.11, “Ethical Innovation in Medical Practice”; 11.1.2, “Physician Stewardship of Health Care Resources”; 11.2.1, “Professionalism in Health Care Systems”; and 1.1.6, “Quality” | In light of the foregoing, the Council on Ethical and Judicial Affairs recommend that Opinion 1.2.11, “Ethically Sound Innovation in Medical Practice”; Opinion 11.2.1, “Professionalism in Health Care Systems”; Opinion 11.1.2, “Physician Stewardship of Health Care Resources”; and Opinion 1.1.6, “Quality,” be amended as follows and the remainder of this report be filed:1. Opinion 1.2.11, Ethically Sound Innovation in Clinical PracticeInnovation in medicine can span a wide range of activities. ~~From~~ It encompasses not only improving an existing intervention, ~~to introducing an innovation in one’s own clinical practice for the first time, to~~ using an existing intervention in a novel way, or translating knowledge from one clinical context into another but also developing or implementing new technologies to enhance diagnosis, treatment, and health care operations. Innovation shares features with both research and patient care, but it is distinct from both.When physicians participate in developing and disseminating innovative practices, they act in accord with professional responsibilities to advance medical knowledge, improve quality of care, and promote the well-being of individual patients and the larger community. Similarly, these responsibilities are honored when physicians enhance their own practices by expanding the range of tools, techniques, ~~and~~ or interventions they ~~offer to patients~~ employ in providing care.Individually, physicians who are involved in designing, developing, disseminating, or adopting innovative modalities should:1. Innovate on the basis of sound scientific evidence and appropriate clinical expertise.
2. Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation.
3. Design innovations so as to minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients.
4. Be sensitive to the cost implications of innovation.
5. Be aware of influences that may drive the creation and adoption of innovative practices for reasons other than patient or public benefit.

When they offer existing innovative diagnostic or therapeutic services to individual patients, physicians must:1. Base recommendations on patients’ medical needs.
2. Refrain from offering such services until they have acquired appropriate knowledge and skills.

(h) Recognize that in this context informed decision making requires the physician to disclose:1. how a recommended diagnostic or therapeutic service differs from the standard therapeutic approach if one exists;

(ii) why the physician is recommending the innovative modality;(iii) what the known or anticipated risks, benefits, and burdens of the recommended therapy and alternatives are;(iv) what experience the professional community in general and the physician individually has had to date with the innovative therapy;(v) what conflicts of interest the physician may have with respect to the recommended therapy.1. Discontinue any innovative therapies that are not benefiting the patient.
2. Be transparent and share findings from their use of innovative therapies with peers in some manner. To promote patient safety and quality, physicians should share both immediate or delayed positive and negative outcomes.

To promote responsible innovation, health care institutions and the medical profession should:(k) Ensure that innovative practices or technologies that are made available to physicians meet the highest standards for scientifically sound design and clinical value.(~~k~~l) Require that physicians who adopt ~~innovative treatment or diagnostic techniques~~ innovations into their practice have ~~appropriate~~ relevant knowledge and skills.(~~l~~m)Provide meaningful professional oversight of innovation in patient care.(~~m~~n)Encourage physician-innovators to collect and share information about the resources needed to implement their ~~innovative therapies~~ innovations safely, effectively, and equitably.2. Opinion 11.2.1, Professionalism in Health Care SystemsContaining costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients’ choices, the patient-physician relationship, and physicians’ relationships with fellow health care professionals.Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other ~~tools~~ mechanisms intended to influence decision making, may impinge on physicians’ exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.Physicians in leadership positions within health care organizations and the profession should ~~ensure that practices for financing and organizing the delivery of care~~:1. Ensure that decisions to implement practices or tools for organizing the delivery of care ~~A~~are transparent and reflect input from key stakeholders, including physicians and patients.
2. ~~Reflect input from key stakeholders, including physicians and patients~~.

(b) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.(c) Ensure ~~ethically acceptable incentives~~ that all such tools:(i) are designed in keeping with sound principles and solid scientific evidence.1. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.
2. Practice guidelines, formularies, and ~~other~~ similar tools should be based on best available evidence and developed in keeping with ethics guidance.

c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;(iv) mitigate possible conflicts between physicians’ financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.(d) Encourage, rather than discourage, physicians (and others) to:(i) provide care for patients with difficult to manage medical conditions;(ii) practice at their full capacity, but not beyond.(e) Recognize physicians’ primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.(f) ~~Are~~ Ensure that the use of financial incentives and other tools is routinely monitored to:(i) identify and address adverse consequences;(ii) identify and encourage dissemination of positive outcomes.All physicians should:(g) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.1. Advocate for changes ~~in health care payment and delivery models~~ how the delivery of care is organized to promote access to high-quality care for all patients.

3. Opinion 11.1.2, Physician Stewardship of Health Care ResourcesPhysicians’ primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians’ primary obligation to serve the interests of individual patients.To fulfill their obligation to be prudent stewards of health care resources, physicians should:1. Base recommendations and decisions on patients’ medical needs.
2. Use scientifically grounded evidence to inform professional decisions when available.
3. Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.
4. Endorse recommendations that offer reasonable likelihood of achieving the patient’s health care goals.
5. Use technologies that have been demonstrated to meaningfully improve clinical outcomes to ~~C~~choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.
6. Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.
7. Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:(h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship. (i) Advocating that health care organizations make available well-validated technologies to enhance diagnosis, treatment planning, and prognosis and support equitable, prudent use of health care resources.(~~i~~j) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect resource utilization and overall health care spending. (jk) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.4. Opinion 1.1.6, QualityAs professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:1. Keeping current with best care practices and maintaining professional competence.
2. Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.
3. Using new technologies and innovations that have been demonstrated to improve patient outcomes and experience of care, in keeping with ethics guidance on innovation in clinical practice and stewardship of health care resources.

(~~c~~d) Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools. |
| .Con | Res 001 | MSS | Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers | RESOLVED, That American Medical Association Policy H-430.983, “Reducing the Use of Restrictive Housing in Prisoners with Mental Illness,” be amended by addition and deletion to read as follows:~~Reducing~~ Opposing the Use of Restrictive Housing ~~in~~ for Prisoners ~~with Mental Illness~~ H-430.983 Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length~~, with rare exceptions,~~ for incarcerated persons ~~with mental illness~~, in ~~adult~~ correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for as short a time as possible; ~~and~~ (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~ (New HOD Policy) |
| .Con | Res 002 | MSS | Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent | RESOLVED, That our American Medical Association add “Middle Eastern/North African (MENA)” as a separate race category on all AMA demographics forms (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all surveys conducted by the U.S. Census Bureau, and for all federally funded research using race categories (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a separate race category on all medical school and residency demographics forms. (Directive to Take Action) |
| .Con | Res 003 | MSS | Supporting the Study of Reparations as a Means to Reduce Racial Inequalities | RESOLVED, That our American Medical Association study potential mechanisms of national economic reparations that could improve inequities associated with institutionalized, systematic racism and report back to the House of Delegates (Directive to Take Action); and be it furtherRESOLVED, That our AMA study the potential adoption of a policy of reparations by the AMA to support the African American community currently interfacing with, practicing within, and entering the medical field and report back to the House of Delegates (Directive to Take Action); and be it furtherRESOLVED, That our AMA support federal legislation that facilitates the study of reparations. (Directive to Take Action) |
| .Con | Res 004 | MSS | Guidelines on Chaperones for Sensitive Exams | RESOLVED, That our American Medical Association ask the Council on Ethical and Judicial Affairs to consider amending E-1.2.4, “Use of Chaperones in Code of Medical Ethics,” to ensure that it is most in line with the current best practices and potentially considers the following topics: a) opt-out chaperones for breast, genital, and rectal exams; b) documentation surrounding the use or not-use of chaperones; c) use of chaperones for patients without capacity; and d) asking patients’ consent regarding the gender of the chaperons and attempting to accommodate that preference as able. (Directive to Take Action) |
| .Con | Res 005 | MSS | Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism | RESOLVED, That our American Medical Association recognize that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination (New HOD Policy); and be it further RESOLVED, That our AMA oppose discrimination against individuals based on their hair or cultural headwear in health care settings (New HOD Policy); and be it furtherRESOLVED, That our AMA acknowledge the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace (New HOD Policy); and be it furtherRESOLVED, That our AMA encourage medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace. (New HOD Policy) |
| .Con | Res 006 | MSS | Evaluating Scientific Journal Articles for Racial and Ethnic Bias | RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means; (New HOD Policy) and be it furtherRESOLVED, That our AMA support major journal publishers implementing a screening method for future research submission concerning the incorrect use of race and ethnicity. (New HOD Policy)  |
| .Con | Res 007 | MSS | Exclusion of Race and Ethnicity in the First Sentence of Case Reports | RESOLVED, That our American Medical Association encourage curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation (New HOD Policy); and be it further RESOLVED, That our AMA encourages the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation. (New HOD Policy) |
| .Con | Res 008 | MSS | Amendment to Truth and Transparency in Pregnancy Counseling Centers, H‑420.954 | RESOLVED, That our American Medical Association amend Policy H-420.954, “Truth and Transparency in Pregnancy Counseling Centers,” by addition and deletion to read as follows, to further strengthen our AMA policy against the dissemination of purposely incomplete or deceptive information intended to mislead patients and the utilization of state and federal funds for potentially biased services provided by pregnancy counseling centers:**Truth and Transparency in Pregnancy Counseling Centers H-420.954**1. Our AMA ~~supports~~ advocates that any entity offering crisis pregnancy services disclose information on site, in its advertising; and before any services are provided concerning medical services, contraception, termination of pregnancy or referral for such services, adoption options or referral for such services that it does and does not provide, as well as fully disclose any financial, political, or religious associations which such entities may have; 2. Our AMA discourages the use of marketing, counseling, or coercion (by physical, emotional, or financial means) by any agency offering crisis pregnancy services that aim to discourage or interfere with a pregnant woman’s pursuit of any medical services for the care of her unplanned pregnancy;3. Our AMA advocates that any entity providing medical or health services to pregnant women that markets medical or any clinical services abide by licensing requirements and have the appropriate qualified licensed personnel to do so and abide by federal health information privacy laws, and additionally disclose their level of compliance to such requirements and laws to patients receiving services; 4. Our AMA opposes the utilization of state and federal funding to finance such entities offering crisis pregnancy services, which do not provide statistically validated evidence-based medical information and care to pregnant women**.** (Modify Current HOD Policy) |
| .Con | Res 009 | MSS | Banning the Practice of Virginity Testing | RESOLVED, That our American Medical Association advocate for the elimination of the practice of virginity testing exams, physical exams purported to assess virginity (Directive to Take Action); and be it furtherRESOLVED, That our AMA support culturally-sensitive counseling by health professionals to educate patients and family members about the negative effects and inaccuracy of virginity testing and where needed, referral for further psychosocial support (New HOD Policy); and be it furtherRESOLVED, That our AMA support efforts to educate medical students and physicians about the continued existence of the practice of virginity testing and its detrimental effects on patients. (New HOD Policy) |
| .Con | Res 010 | MSS | Improving the Health and Safety of Sex Workers | RESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing consensual sex work (New HOD Policy); and be it furtherRESOLVED, That our AMA: 1) support legislation that decriminalizes individuals who offer sex in return for money or goods; 2) oppose legislation that decriminalizes sex buying and brothel keeping; and 3) support the expungement of criminal records of those previously convicted of sex work, including trafficking survivors (New HOD Policy); and be it further RESOLVED, That our AMA support research on the long-term health, including mental health, impacts of decriminalization of the sex trade. (New HOD Policy) |
| .Con | Res 011 | MSS | Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions | RESOLVED, That our American Medical Association amend Policy H-185.990, “Infertility and Fertility Preservation Insurance Coverage,” by addition to read as follows:**Infertility and Fertility Preservation Insurance Coverage H-185.990**It is the policy of the AMA that (1) Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; (2) Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; and (3) Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility. (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA amend Policy H-185.950, “Removing Financial Barriers to Care for Transgender Patients,” by addition to read as follows:**Removing Financial Barriers to Care for Transgender Patients H-185.950**Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient’s physician, including gender-affirming hormone therapy and gender-affirming surgery. (Modify Current HOD Policy) |
| .Con | Res 012 | MSS | Increased Recognition and Treatment of Eating Disorders in Minority Populations  | RESOLVED, That our American Medical Association amend Policy H-150.965, “Eating Disorders,” by addition to read as follows in order to support increased recognition of disordered eating behaviors in minority populations and culturally appropriate interventions: H-150.965 – EATING DISORDERSThe AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one’s physical and mental health as obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians, counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, binge-eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for culturally-informed interventional counseling; and (4) participates in this effort by consulting with appropriate and culturally informed educational and counseling materials pertaining to unhealthy eating, binge-eating*,* dieting, and weight restrictive behaviors. (Modify Current HOD Policy) |
| .Con | Res 013 | MSS | Equal Access to Adoption for the LGBTQ Community | RESOLVED, That our American Medical Association advocate for equal access to adoption services for LGBTQ individuals who meet federal criteria for adoption regardless of gender identity or sexual orientation (Directive to Take Action); and be it furtherRESOLVED, That our AMA encourage allocation of government funding to licensed child welfare agencies that offer adoption services to all individuals or couples including those with LGBTQ identity. (New HOD Policy) |
| .Con | Res 015 | MSS | Using X-Ray and Dental Records for Assessing Immigrant Age | RESOLVED, That our American Medical Association support discontinuation of the use of non-medically necessary dental and bone forensics to assess an immigrant’s age. (New HOD Policy) |
| .Con | Res 016 | MSS | Student-Centered Approaches for Reforming School Disciplinary Policies | RESOLVED, That our American Medical Association support evidence-based frameworks in K‑12 schools that focus on school-wide prevention and intervention strategies for student misbehavior (New HOD Policy); and be it furtherRESOLVED, That our AMA support the inclusion of school-based mental health professionals in the student discipline process. (New HOD Policy) |
| .Con | Res 017 | WPS | Gender Equity and Female Physician Work Patterns During the Pandemic | RESOLVED, That our American Medical Association advocate for research on physician-specific data analyzing changes in work patterns and employment outcomes among female physicians during the pandemic including, but not limited to, understanding potential gaps in equity, indications for terminations and/or furloughs, gender differences in those who had unpaid additional work hours, and issues related to intersectionality (Directive to Take Action); and be it furtherRESOLVED, That our AMA collaborate with relevant organizations to evaluate obstacles affecting female physicians and medical students during the pandemic. (Directive to Take Action) |
| .Con | Res 018 | RFS | Support for Safe and Equitable Access to Voting | RESOLVED, That our AMA support measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours;(b) increasing the number of polling locations;(c) extending early voting periods;(d) mail-in ballot postage that is free or prepaid by the government;(e) adequate resourcing of the United States Postal Service and election operational procedures;(f) improve access to drop off locations for mail-in or early ballots (New HOD Policy); and be it furtherRESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail. (New HOD Policy) |
| .Con | Res 019 | RFS | Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent | RESOLVED, That our American Medical Association add “Middle Eastern/North African (MENA)” as a separate racial category on all AMA demographics forms (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for the use of “Middle Eastern/North African (MENA)” as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education. (Directive to Take Action) |
| .Con | Res 020\* | Iowa | Recognizing and Remedying “Structural Urbanism” Bias as a Factor in Rural Health Disparities | RESOLVED, That our American Medical Association: (1) formally recognize that systemic bias in healthcare financing, called “Structural Urbanism,” has been a factor in leading to rural health disparities; (2) in future AMA strategic planning to reduce all of America’s health disparities, include plans to reduce/remedy the structural urbanism bias; and (3) point out, in advocating for health equity for all Americans, that Medicare payment policies have played a role in the shortage of rural physicians and the poorer health outcomes in rural America (Directive to Take Action); and be it furtherRESOLVED, That our AMA, as part of our current advocacy for telehealth reform, specify that geographic payment equity be required in any telehealth legislation. (Directive to Take Action) |
| .Con | Res 021\* | Louisiana | Free Speech and Civil Discourse in the American Medical Association | RESOLVED, That it be the policy of our American Medical Association that:Our American Medical Association unequivocally commits to truly open discourse, debate, exchange of ideas, and argument;Our American Medical Association unequivocally commits to a culture which recognizes the inherent dignity and worth of its members, which resolves that freedom of expression and civility must coexist, and where those who disagree will do so without enmity; Our American Medical Association unequivocally commits to the principle that dissenting and unpopular voices must be afforded the opportunity to be heard;Our American Medical Association unequivocally commits that members of the American Medical Association of different faiths, philosophies, and persuasions may speak their minds and honor their deepest convictions without fear of punishment or retaliation;Our American Medical Association unequivocally commits that the mere exposure to ideas that some may find offensive is not an act of violence or hatred; Our American Medical Association unequivocally commits to a prohibition of the listing of people or organizations to be regarded as unacceptable, untrustworthy, excluded, or avoided based on ideological positions or differences;Our American Medical Association unequivocally commits that ideological demonization of opponents to block debate and to silence disagreement in the proceedings of the American Medical Association is unprofessional conduct subject to appropriate disciplinary action;Our American Medical Association unequivocally commits that defamation, obscenity, intimidation, threats, and incitement to violence, have no place in the proceedings of the American Medical Association, and if exhibited are unprofessional conduct subject to appropriate disciplinary action. (New HOD Policy) |
| .Con | Res 022\* | Louisiana | Prohibition of Racist Characterization Based on Personal Attributes | RESOLVED, That it be the policy of our American Medical Association that no person or group of persons shall be considered or characterized as racist based on personal attributes of race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, age, disability, or genetic information. (New HOD Policy) |
| .Con | Res 023# | Pennsylvania | AMA Council on Ethical and Judicial Affairs (CEJA) report on Physician Responsibilities to Impaired Colleagues: CEJA E-9.3.2 | RESOLVED, That our American Medical Association support a fair, objective, external and independent review for physicians who are requested to be assessed for a potential impairment, and support the availability of physician health programs to enable physicians who require assistance to provide safe and effective care (New HOD Policy); and be it further RESOLVED, That our AMA advocate that health system, corporate, and academic organizations provide a fair, objective, external and independent review for physicians who are requested to be assessed for a potential impairment (Directive to Take Action); and be it furtherRESOLVED, That the Council on Ethical and Judicial Affairs consider the following amendment to Opinion E-9.3.2, “Physician Responsibilities to Colleagues with Illness, Disability or Impairment”: (i) Advocating for supportive services including physician health programs and accommodations to enable physicians who require assistance to provide safe, effective care.…(k) Advocating for fair, objective, external, and independent review for physicians when a review is requested to assess a potential impairment and its duration. (Modify Current HOD Policy) |
| .Con | Res 024# | Pennsylvania | Organ Transplant Equity for Persons with Disabilities | RESOLVED, That our American Medical Association support equitable inclusion of people with intellectual and developmental disabilities (IDD) in eligibility for transplant surgery (New HOD Policy); and be it further RESOLVED, That our AMA support individuals with IDD having equal access to organ transplant services and protection from discrimination in rendering these services (New HOD Policy); and be it further RESOLVED, That our AMA support the goal of the Organ Procurement and Transplantation Network (OPTN) in adding disability status to their Nondiscrimination policy under the National Organ Transplant Act of 1984 (New HOD Policy); and be it further RESOLVED, That our AMA work with relevant stakeholders to distribute antidiscrimination education materials for healthcare providers related to equitable inclusion of people with IDD in eligibility for transplant surgery. (Directive to Take Action) |
| .Con | Res 025# | New York | Opposition to Discriminatory Treatment of Haitian Asylum Seekers | RESOLVED, That our American Medical Association oppose discrimination against Haitian asylum seekers which denies them the same opportunity to attain asylum status as individuals from other nations. (New HOD Policy) |
| .Con | Res 026# | MSS | Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates | RESOLVED, That our American Medical Association update its Special Meeting procedures by updating the Special Meetings Bylaws as follows:1. Specification that the processes used to determine which items of business meet or do not meet the purpose for which the Special Meeting is called shall be published online and electronically sent to all members of the House of Delegates prior to the initiation of the Special Meeting.
2. Specification concerning the processes for how formal feedback may be submitted and reviewed prior to, during, and after the conclusion of the Special Meeting.
3. Description of how a Special Meeting report, detailing the processes that were used in the meeting, along with a summary of the concerns and suggestions submitted by the formal feedback mechanism, shall be produced by the Speakers and Board of Trustees following each Special Meeting that occurs.
4. Description of how, after each Special Meeting, a committee that is representative of House membership shall be formed for the purpose of (a) reviewing the Special Meeting and (b) proposing any improvements to the processes for future Special Meetings. (Modify Current HOD Policy)
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| .Con | Speakers’ Report 01 | n/a | Report of the Election Task Force | This report from your speakers spells out the expectations for interviews, particularly virtual interviews, conducted with those seeking election to leadership positions within our AMA. It is recommended that Policy G-610.020 be amended by addition and deletion to read as follows and the remainder of this report be filed. [Note: Paragraph numbers will be editorially corrected as required.](4) Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card ~~and their conflict of interest statement~~ to the House Office. They will then be included in all subsequent projections of announcements before the House, “Official Candidate Notifications,” and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times.…(11) The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker). Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual’s contact information to the Office of House of Delegates Affairs. The Speaker’s Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information as requested.(12) Interviews conducted with current candidates must comply with the following rules:a. Interviews may be arranged between the parties once active campaigning is allowed.b. Groups conducting interviews with candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group’s interview schedule is finalized.i. A group may meet with a candidate who is a member of their group without interviewing other candidates for the same office.ii. Interviewing groups may, but are not required to, interview late announcing candidates. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity.iii. Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews.c. Groups may elect to conduct interviews virtually or in-person, but not both. All interviews for an office must be conducted using the same format and platform.d. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.e. Virtual interviews are subject to the following constraints:i. Interviews may be conducted only during a window beginning on the Friday evening two weekends prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place and must be concluded by the Sunday evening one week before the scheduled Opening Session of the House.ii. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8 am and 10 pm based on the candidate’s local time, unless another mutually acceptable time outside these hours is arranged.iii. Caucuses and delegations scheduling interviews for candidates within the parameters above are not obligated to offer alternatives but are encouraged to do so if possible.f. Recording of interviews is allowed only with the knowledge and consent of the candidate.g. Recordings of interviews may be shared only among members of the group conducting the interview.h. A candidate is free to decline any interview request.i. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations. |
| .Con | Speakers’ Report 02 | n/a | Establishing an Election Committee | 1. A Campaign Complaint Reporting, Validation, and Resolution Process shall be established as follows:Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:* The name of the person(s) thought to have violated the rules
* The date of the alleged violation and the location if relevant
* The specific violation being alleged (i.e., the way the rules were violated)
* The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.

Campaign violation complaints will be investigated by the Election Committee, which will determine penalties for validated complaints as appropriate. Penalties may include an announcement of the violation by the Speaker to the House. (New HOD Policy)2. The Election Committee will review the Campaign Complaint Reporting, Validation, and Resolution Process as implemented and make further recommendations to the House as necessary. (Directive to Take Action)3. Policy D-610.998, Paragraph 6 be rescinded. (Rescind HOD Policy) |
| A | CMS 01 | n/a | End-of-Life Care | 1. That our American Medical Association (AMA) support Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare’s hospice benefit. (New HOD Policy)
2. That our AMA support study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare’s hospice and skilled nursing facility (SNF) benefits for the same condition. (New HOD Policy)
3. That our AMA support increased access to palliative care services by Medicare patients in skilled nursing facilities. (New HOD Policy)
4. That our AMA reaffirm Policy H-85.966, which maintains that hospice care should provide the patient and family with appropriate physical and emotional support, but not preclude the use of appropriate palliative therapies to continue to treat underlying disease. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-70.915, which recognizes the importance of palliative care, encourages the education of health professionals and the public in caring for dying patients, and supports improved payment for health care practices that are important to good care of the dying patient. (Reaffirm HOD Policy)
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| A | CMS 03 | n/a | Covering the Remaining Uninsured | 1. That our American Medical Association (AMA) advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid–having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility–make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections. (New HOD Policy)
2. That our AMA advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions. (New HOD Policy)
3. That our AMA support extending eligibility to purchase unsubsidized Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status. (New HOD Policy)
4. That our AMA recognize the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. (New HOD Policy)
5. That our AMA reaffirm Policy H-290.983, which opposes federal and state legislation denying or restricting lawfully present immigrants Medicaid and immunizations. (Reaffirm HOD Policy)
6. That our AMA amend Policy H-165.828 by addition and deletion to read as follows:
7. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to ~~that which applies to the~~ ~~exemption from the individual mandate of~~ the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
8. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA’s “family glitch,” thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage ~~with respect to the cost of family-based or employee-only coverage~~ and household income. … (Modify Current HOD Policy)
9. That our AMA reaffirm Policy D-290.979, which states that our AMA will work with state and specialty medical societies in advocating at the state level in support of Medicaid expansion. (Reaffirm HOD Policy)
10. That our AMA reaffirm Policy H-290.965, which supports states that newly expand Medicaid being made eligible for three years of full federal funding. (Reaffirm HOD Policy)
11. That our AMA reaffirm Policy H-165.823, which supports auto-enrolling individuals in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies, including zero-premium marketplace coverage and Medicaid/Children’s Health Insurance Program (CHIP); and outlines standards that any public option to expand health insurance coverage must meet. (Reaffirm HOD Policy)
12. That our AMA reaffirm Policy H-165.838, which states that insurance coverage options offered in a health insurance exchange should be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. (Reaffirm HOD Policy)
13. That our AMA reaffirm Policy H-165.824, which supports: (1) adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (2) providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; (3) state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections; (4) eliminating the subsidy “cliff,” thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL); (5) increasing the generosity of premium tax credits; (6) expanding eligibility for cost-sharing reductions; and (7) increasing the size of cost-sharing reductions. (Reaffirm HOD Policy)
14. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which support investments in Medicaid/CHIP outreach and enrollment assistance activities. (Reaffirm HOD Policy)
15. That our AMA reaffirm Policy H-165.848, which supports a requirement that individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. (Reaffirm HOD Policy)
16. That our AMA rescind Policy H-290.966, as it is superseded by Policy H-165.823 as well as the recommendations of this report. (Rescind HOD Policy)
17. That our AMA reaffirm Policy H-330.896, which supports restructuring Medicare age-eligibility requirements and incentives to match the Social Security schedule of benefits. (Reaffirm HOD Policy)
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| A | CMS 05 | n/a | Integrating Care for Individuals Dually Eligible for Medicare and Medicaid | 1. That our American Medical Association (AMA) support integrated care for individuals dually eligible for Medicare and Medicaid that aligns with AMA policy and meets the following criteria:
	1. Care is grounded in the diversity of dually eligible enrollees and services are tailored to individuals’ needs and preferences.
	2. Coverage of medical, behavioral health, and long-term services and supports is aligned.
	3. Medicare and Medicaid eligibility and enrollment processes are simplified, with enrollment assistance made available as needed.
	4. Enrollee choice of plan and physician is honored, allowing existing patient-physician relationships to be maintained.
	5. Services are easy to navigate and access, including in rural areas.
	6. Care coordination is prioritized, with quality case management available as appropriate.
	7. Barriers to access, including inadequate networks of physicians and other providers and prior authorizations, are minimized.
	8. Administrative burdens on patients, physicians and other providers are minimized.
	9. Educational materials are easy to read and emphasize that the ability and power to opt in or out of integrated care resides solely with the patient.
	10. Physician participation in Medicare or Medicaid is not mandated nor are eligible physicians denied participation. (New HOD Policy)
2. That our AMA reaffirm Policy H-290.967, which establishes principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible patients. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy D-290.978, which calls on the Centers for Medicare & Medicaid Services to require all states to develop processes to facilitate opting out of managed care programs by dual eligible individuals. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-165.822, which encourages new and continued partnerships to address non-medical health needs and the underlying social determinants of health; supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-180.944, which states that health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health services, research and data collection; promoting equity in care; increasing health workforce diversity; influencing social determinants of health; and voicing and modeling commitment to health equity. (Reaffirm HOD Policy)
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| A | Res 101 | Virginia | Standardized Coding for Telehealth Services | RESOLVED, That our American Medical Association advocate by regulation and/or legislation that telehealth services are uniformly identified by using place of service (02) without any additional requirements, such as modifiers imposed by third party payors, for claim submission and reimbursement. (Directive to Take Action) |
| A | Res 102 | SPS | Prevention of Hearing Loss-Associated-Cognitive-Impairment through Earlier Recognition and Remediation | RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment in later life, to physicians as well as to the public (Directive to Take Action); and be it furtherRESOLVED, That our AMA promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote, the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment and amenable to correction (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for increased hearing screening, and expanding all avenues for third party coverage for effective hearing loss remediation beginning in mid-life or whenever detected, especially when such loss is shown conclusively to contribute significantly to the development of, or to magnify the functional deficits of cognitive impairment, and/or to limit the capacity of individuals for independent living. (Directive to Take Action) |
| A | Res 103 | SPS | Oral Healthcare IS Healthcare | RESOLVED, That our American Medical Association reaffirm that dental and oral health are integral components of basic health care and maintenance regardless of age (Reaffirm HOD Policy); and be it furtherRESOLVED, That our AMA, through the Center for Healthcare Equity, highlight the substantial contribution of dental and oral healthcare disparities to health inequity as well as to social and economic disparities (Directive to Take Action); and be it furtherRESOLVED, That our AMA support ongoing research, legislative actions and administrative efforts to promote access to and adequate coverage in the public and private payers by preventative and therapeutic dental services as integral parts of overall health maintenance to all populations (New HOD Policy); and be it furtherRESOLVED, That our AMA work with other organizations to explore avenues to promote efforts to expand Medicare benefits to include preventative and therapeutic dental services without increasing the already proposed decrease in Medicare Part B Reimbursements. (Directive to Take Action) |
| A | Res 104 | New England | Improving Access to Vaccinations for Patients | RESOLVED That our American Medical Association encourage all payors, including the Centers for Medicare and Medicaid Services, to cover, without cost sharing, all vaccines recommended by the Centers for Disease Control and Prevention, when administered in the physician office. (Directive to Take Action) |
| A | Res 105 | WPS | Fertility Preservation Insurance Coverage for Women in Medicine | RESOLVED, That our American Medical Association advocate for fertility preservation as a covered employee benefit through employer paid insurance plans or cash reimbursement for women in medicine. (Directive to Take Action) |
| A | Res 106 | MSS | Reimbursement of School-Based Health Centers | RESOLVED, That our American Medical Association amend Policy H-60.921, “School-Based and School-Linked Health Centers,” by addition and deletion to read as follows:**School-Based and School-Linked Health Centers, H-60.921****1.** Our AMA supports ~~the concept of adequately equipped and staffed~~ the implementation, maintenance, and equitable expansion of school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.2. Our AMA recognizes that school-based health centers increase access to care in underserved child and adolescent populations. 3. Our AMA supports identifying school-based health centers in claims data from Medicaid and other payers for research and quality improvement purposes.4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid. (Modify Current HOD Policy) |
| A | Res 107 | MSS | Expanding Medicaid Transportation to Include Healthy Grocery Destinations | RESOLVED, That our American Medical Association: (1) support the implementation and expansion of transportation services for accessing healthy grocery options; and (2) advocate for inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations offered by Medicaid transportation at the federal level; and (3) support efforts to extend Medicaid reimbursement to non-emergent medical transportation for healthy grocery destinations. (Directive to Take Action) |
| A | Res 108 | MSS | Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes | RESOLVED, That our American Medical Association advocate for broadening the classification criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic glucose monitors (Directive to Take Action); and be it furtherRESOLVED, That our AMA amend AMA Policy H-330.885 by addition and deletion to read as follows: ~~Medicare~~ Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885Our AMA supports efforts to achieve ~~Medicare~~ coverage of continuous and flash glucose monitoring systems for all patients with ~~insulin-dependent~~ diabetes by all public insurance programs. (Modify Current HOD Policy) |
| A | Res 109 | MSS | Amending D-440.985, “Health Care Payment for Undocumented Persons,” to Study Methods to Increase Health Care Access for Undocumented Immigrants | RESOLVED, That our American Medical Association amend Policy D-440.985, “Health Care Payment for Undocumented Persons,” by addition to read as follows: Health Care Payment for Undocumented Persons D-440.985Our American Medical Association: (1) shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level~~.~~; and (2) support methods to increase health insurance access for undocumented immigrants, such as allowing them to purchase health insurance on the Affordable Care Act marketplaces. (Modify Current HOD Policy) |
| A | Res 110 | MSS | Caps on Insulin Co-Payments for Patients with Insurance | RESOLVED, That our American Medical Association amend Policy H-110.984, “Insulin Affordability,” by addition to read as follows: Insulin Affordability H-110.984Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; ~~and~~ (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies~~.~~; and (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin. (Modify Current HOD Policy) |
| A | Res 111 | MSS | Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System | RESOLVED, That our American Medical Association amend Policy H-60.910 by addition and deletion to read as follows:Addressing Healthcare Needs of ~~Children~~ Youth in Foster Care1. Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of youth ~~children~~ in foster care.

Our AMA advocates that all youth currently in foster care remain eligible for Medicaid or other publicly funded health coverage in their state until at least 26 years of age. (Modify Current Policy) |
| A | Res 112 | American Thoracic Society | Expanding Coverage for and Access to Pulmonary Rehabilitation | RESOLVED, That our American Medical Association advocate for insurance coverage for and access to pulmonary rehabilitation for any patient with chronic lung disease or chronic shortness of breath. (Directive to Take Action) |
| A | Res 113 | California | Supporting Medicare Drug Price Negotiation | RESOLVED, That our American Medical Association aggressively advocate for passage of legislation that authorizes Medicare to negotiate drug prices with pharmaceutical companies to bring down the cost of prescription drugs for our patients (Directive to Take Action); and be it furtherRESOLVED, That our AMA amend Policy H-110.980, “Additional Mechanisms to Address High and Escalating Pharmaceutical Prices” to support indexing Medicare Part D drug prices to a reasonable percentage of the prices paid in other large western industrialized nations by addition and deletion to read as follows: H-110.980 - Additional Mechanisms to Address High and Escalating Pharmaceutical Prices2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:a. ~~Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;b. Any international drug price index or average should not be used to determine or set a drug’s price, or determine whether a drug’s price is excessive, in isolation;~~a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug’s volume-weighted net average price in at least six large western industrialized nations;~~c~~.b. The use of any international drug price index or average should preserve patient access to necessary medications;~~d~~.c. The use of any international drug price index or average should limit burdens on physician practices; and~~e~~.d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly~~.~~; ande. Any international drug price index used to determine Medicare Part D drug prices should ensure that American taxpayers are not unnecessarily subsidizing drug costs in other large western industrialized nations. (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA support legislation that limits Medicare annual drug price increases to the rate of inflation (New HOD Policy); and be it furtherRESOLVED, That our AMA support legislation that reinvests a portion of any savings from Medicare drug price negotiation into the Medicare physician fee schedule and other Medicare physician value-based payments. (New HOD Policy)  |
| A | Res 114 | New Mexico | Medicare and Private Health Insurance for Hearing Aids | RESOLVED, That our American Medical Association support Congress expanding Medicare Coverage for medical grade hearing aids (New HOD Policy); and be it furtherRESOLVED, That our AMA advocate for coverage with minimal copays or coinsurance for medical-grade hearing aids as medically necessary for all health insurance, including Medicaid. (Directive to Take Action)  |
| A | Res 115 | Ohio | Bundled Payments and Medically Necessary Care | RESOLVED, That our American Medical Association study the issue of “Bundled Payments and Medically Necessary Care” and report back to the AMA House of Delegates at 2022 Annual Meeting, to make sure that our health care system is reasonable and fair to all, allows medically appropriate and necessary care for our patients, and allows for fair reimbursement for physicians. (Directive to Take Action) |
| A | Res 116 | RFS | Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance | RESOLVED, That our American Medical Association recognize the importance of providing avenues for affordable health insurance coverage and health care access to patients who do not have employer-sponsored health insurance, or for whom employer-sponsored health insurance does not meet their needs (New HOD Policy); and be it furtherRESOLVED, That our AMA recognize that a significant and increasing proportion of patients are unable to meet their health insurance or health care access needs through employer-sponsored health insurance, and that these patients must be considered in the course of ongoing efforts to reform the healthcare system in pursuit of universal health insurance coverage and health care access. (New HOD Policy) |
| A | Res 117 | RFS | Implant-Associated Anaplastic Large Cell Lymphoma | RESOLVED, That our American Medical Association support appropriate coverage of cancer diagnosis, treating surgery and other systemic treatment options for implant-associated anaplastic large cell lymphoma. (New HOD Policy) |
| A | Res 118 | Texas | Expanding Site-of-Service Neutrality | RESOLVED, That our American Medical Association continue to support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments (Directive to Take Action); and be it furtherRESOLVED, That our AMA pursue and support passage of legislation and agency policies that expand site-neutral payment to equalize payments across sites of service for all outpatient services (Directive to Take Action); and be it furtherRESOLVED, That our AMA pursue policy that creates patient incentives for services to be performed in the most cost-effective location, such as a physician’s office.(Directive to Take Action) |
| A | Res 119\* | New York | Bundling Physician Fees with Hospital Fees | RESOLVED, That our American Medical Association oppose bundling of physician payments with hospital payments, unless the physician has agreed to such an arrangement in advance. (New HOD Policy) |
| A | Res 120\* | New York | COBRA for College Students | RESOLVED, That our American Medical Association call for legislation similar to COBRA to allow college students to continue their healthcare coverage, at their own expense, for up to 18 months after graduation or other termination of enrollment. (Directive to Take Action) |
| A | Res 121\* | New York | Medicaid Tax Benefits | RESOLVED, That our American Medical Association advocate for legislation that would allow physicians who take care of Medicaid or uninsured patients to receive some financial benefit through a tax deduction such as (a) a reduced rate of overall taxation or (b) the ability to use the unpaid charges for such patients as a tax deduction. (Directive to Take Action) |
| A | Res 122\* | Society of Critical Care Medicine | Increase Funding, Research and Education for Post-Intensive Care Syndrome | RESOLVED, That our American Medical Association support the development of an ICD-10 code or family of codes to recognize Post-Intensive Care Syndrome (PICS) (New HOD Policy); and be it furtherRESOLVED, That our AMA advocate for legislation to provide funding for research and treatment of Post-Intensive Care Syndrome, including for those cases related to COVID-19. (Directive to Take Action) |
| A | Res 123# | Maryland | Support for Easy Enrollment Federal Legislation | RESOLVED, That our American Medical Association support the Easy Enrollment in Health Care Act. (New HOD Policy) |
| A | Res 124# | RFS | Medicare Coverage of Dental, Vision, and Hearing Services | RESOLVED, That our American Medical Association support new Medicare funding that is independent of the physician fee schedule for coverage of: (1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; and (2) routine eye examinations and visual aids, including eyeglasses (New HOD Policy); and be it furtherRESOLVED, That our AMA amend Policy H-185.929, “Hearing Aid Coverage,” by addition to read as follows: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, aural rehabilitative services, and hearing aids 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.
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| A | Res 125# | MSS | Medicare Coverage of Dental, Vision, and Hearing Services | RESOLVED, That our American Medical Association support Medicare coverage of preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures (New HOD Policy); and be it furtherRESOLVED, That our AMA support Medicare coverage of routine eye examinations and visual aids, including eyeglasses and contact lenses (New HOD Policy); and be it furtherRESOLVED, That our American Medical Association amend Policy H-185.929, “Hearing Aid Coverage,” by addition to read as follows:Hearing Aid Coverage H-185.9291. 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, aural rehabilitative services, and hearing aids 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. (Modify Current HOD Policy)  |
| B | BOT 02 | n/a | Policing Reform | The Board recommends that the following be adopted in lieu of the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, and that the remainder of the report be filed.1. That our AMA advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement. (New HOD Policy)2. That our AMA advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death. (New HOD Policy)3. That our AMA encourage further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities. (New HOD Policy)4. That our AMA support greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices. (New HOD Policy)5. That Policy H-65.954, “Policing Reform,” be reaffirmed. (Reaffirm HOD Policy)6. That Policy H-515.955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes,” be reaffirmed. (Reaffirm HOD Policy)7. That Policy H-345.972, “Mental Health Crisis Interventions,” be reaffirmed. (Reaffirm HOD Policy)8. That Policy H-145.969, “Less-Lethal Weapons and Crowd Control,” be reaffirmed. (Reaffirm HOD Policy). |
| B | BOT 08 | n/a | Improved Access and Coverage to Non-opioid Modalities to Address Pain | The Board recommends that the referred resolves in Alternate Resolution 218-A-19 not be adopted and the remainder of the report be filed. |
| B | BOT 09 | n/a | Medical Marijuana License Safety | The Board recommends that the following be adopted in lieu of Resolution 219-A-19 and the remainder of the report be filed.1. That our American Medical Association (AMA) support efforts to limit information about medical cannabis in states’ prescription drug monitoring programs to only whether a patient has been certified to receive medicinal cannabis consistent with AMA principles safeguarding patient privacy and confidentiality; (New HOD Policy)
2. That our AMA continue its monitoring of state legislation relating to the inclusion of cannabis and related information in state PDMPs. (Directive to Take Action)
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| B | BOT 10 | n/a | Physician Access to their Medical and Billing Records | 1. That our AMA advocate that licensed physicians have unrestricted access to all their patients’ billing records and associated medical records during employment or while under contract to provide medical or health care items or services. The records should also include any billing records submitted under the physician’s name, regardless of whether the physician directly provided the item or service. (Directive to Take Action)
2. That our AMA advocate that, where physician possession of all his or her billing records is not already required by state law, the employment or other contractual arrangement between a physician and entity submitting claims on behalf of the physician should specify that the physician is entitled to copies of his or her billing records subsequent to the termination of employment or contractual arrangement, when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. (Directive to Take Action)
3. That our AMA advocate for legislation or regulation to eliminate contractual language that bars or limits the treating physician’s access to his or her billing records and associated medical records, such as treating these records as trade secrets or proprietary. (Directive to Take Action)
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| B | BOT 12 | n/a | Direct-to-Consumer Genetic Tests | 1. That our AMA adopt the following new policy:“Consumer Genetic Testing and Privacy”Our AMA:1. will work with relevant stakeholders to advance laws and regulations that prevent genetic testing entities without explicit, informed, and non-coerced user consent from transferring information about a user such as birthdates and state of residence to third parties which may result in the re-identification of the user based on surname inference (New HOD Policy).
2. supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identifiable information, including DNA, with other parties without informed consent of the user. An exception would be made when requested for a duly executed court order or when compelled for public health or safety reasons as outlined in existing AMA policy including H-315.983, “Privacy and Confidentiality,” and Medical Code of Ethics 4.1.4, “Forensic Genetics.” If a data security or privacy breach occurs with a direct-to-consumer (DTC) genetic company or its collaborators, then the company has the responsibility to inform all users and relevant regulatory bodies of the breach and the impact of the unprotected private data on those individuals (New HOD Policy).
3. will advocate that research using consumer genomic data derived from saliva or cheek swabs or other human samples should be treated as research on human subjects requiring informed consent consistent with or similar to those required by the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an “opt in” option to allow more consumer choice in the consent process (New HOD Policy).
4. will advocate for extending the consumer protections of the Genetic Information Non- Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California (New HOD Policy).

2. That the following policies be reaffirmed: H-65.969, “Genetic Discrimination and the Genetic Information Nondiscrimination Act,” H-185.972, “Genetic Information and Insurance Coverage,” D-480.987, “Direct-to-Consumer Marketing and Availability of Genetic Testing,” H-480.941, “Direct-to-Consumer Laboratory Testing,” H-460.916, “Protection of Human Subjects in Research,” H-460.980, “Ethical and Societal Considerations in Research,” and H‑315.983, “Patient Privacy and Confidentiality” (Reaffirm HOD Policy) |
| B | BOT 14 | n/a | Net Neutrality and Public Health | The Board of Trustees recommends that Resolution 211-I-19, “Effects of Net Neutrality on Public Health,” and Resolution 208-I-19, “Net Neutrality and Public Health,” not be adopted and that the remainder of the report be filed. |
| B | Res 201 | South Carolina | Protection of Peer-Review Process | RESOLVED, That our American Medical Association use its full ability and influence to oppose any new attempt(s) to make peer review proceedings, regardless of the venue, discoverable, even if by the U.S. Congress or other U.S. governmental entity. (Directive to Take Action) |
| B | Res 202 |  |  | RESOLUTION WITHDRAWN. |
| B | Res 203 | MSS | Poverty-Level Wages and Health | RESOLVED, That our American Medical Association support federal minimum wage regulation such that the minimum wage increases at least with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty. (New HOD Policy) |
| B | Res 204 | MSS | Supporting Collection of Data on Medical Repatriation | RESOLVED, That our American Medical Association ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriations from the United States to other countries by medical centers to further identify the harms of this practice (Directive to Take Action); and be it furtherRESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD Policy) |
| B | Res 205 | MSS | Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits | RESOLVED, That our American Medical Association amend Policy H-80.999, “Sexual Assault Survivors,” by addition to read as follows: H-80.999 – SEXUAL ASSAULT SURVIVORS1. 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 limitations (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor’s Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
5. Our AMA will advocate at the state and federal level for (a) the immediate processing of all “backlogged” and new sexual assault examination kits; and (b) additional funding to facilitate the immediate testing of sexual assault evidence kits. (Modify Current HOD Policy)
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| B | Res 206 | MSS | Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises | RESOLVED, That our American Medical Association, in order to prioritize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic:1. oppose the slowing or halting of the release of individuals and families that are currently part of the immigration process; and
2. oppose continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance, community support, bonding, or a formal monitoring program during national crises that impose a health risk; and
3. support the extension or reauthorization of visas that were valid prior to a national crisis if the crisis causes the halting of immigration processing; and
4. oppose utilizing public health concerns to deny of significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution (New HOD Policy); and be it further

RESOLVED, That our AMA amend H-350.957, “Addressing Immigrant Health Disparities,”by addition as follows:Addressing Immigrant and Refugee Health Disparities H-350.9571. Our American Medical Association recognizes the unique health needs of immigrants and refugees and encourages the exploration of issues related to immigrant and refugee health and supports legislation and policies that address the unique health needs of immigrants and refugees.2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities among refugee or immigrant populations by forcing them to choose between health care or future lawful residency status. (Modify Current HOD Policy) |
| B | Res 207 | MSS | Authority to Grant Vaccine Exemptions | RESOLVED, That our American Medical Association oppose medical vaccine exemptions by non-physicians by amending Policy H-440.970, “Nonmedical Exemptions from Immunizations,” by addition to read as follows: Nonmedical Exemptions from Immunizations, H-440.970 1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA: (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only. 2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to: (a) eliminate non-medical exemptions from mandated pediatric immunizations; and (b) limit medical vaccine exemption authority to only licensed physicians. (Modify Current HOD Policy) |
| B | Res 208 | MSS | Protections for Incarcerated Mothers in the Perinatal Period | RESOLVED, That our American Medical Association encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates (New HOD Policy); and be it further RESOLVED, That our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and report pregnancy-related healthcare statistics with transparency in the data collection process (New HOD Policy); and be it furtherRESOLVED, That our AMA amend policy H-430.990 by addition to read as follows:Bonding Programs for Women Prisoners and their Newborn Children H-430.990Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. (Modify Current HOD Policy) |
| B | Res 209 | MSS | Increasing Access to Hygiene and Menstrual Products | RESOLVED, That our American Medical Association recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals (New HOD Policy); and be it further RESOLVED, That our AMA support the inclusion of medically necessary hygiene products, including, but not limited to, menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs (New HOD Policy); and be it further RESOLVED, That our AMA advocate for federal legislation and work with state medical societies to increase access to menstrual hygiene products, especially for recipients of public assistance (Directive to Take Action); and be it further RESOLVED, That our AMA encourage public and private institutions as well as places of work and education to provide free, readily available menstrual care products to workers, patrons, and students (New HOD Policy); and be it further RESOLVED, That our AMA amend H-525.974, “Considering Feminine Hygiene Products as Medical Necessities,” by addition and deletion to read as follows: CONSIDERING FEMININE HYGIENE PRODUCTS AS MEDICAL NECESSITIES, H-525.974 Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; ~~and~~ (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs~~.~~; and (3) encourage 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. (Modify Current HOD Policy) |
| B | Res 210 | MSS | Advocating for the Amendment of Chronic Nuisance Ordinances | RESOLVED, That our American Medical Association advocate for amendments to chronic nuisance ordinances that ensure calls made for safety or emergency services are not counted towards nuisance designations (Directive to Take Action); and be it furtherRESOLVED, That our AMA support initiatives to: (a) gather data on chronic nuisance ordinance enforcement; and (b) make that data publicly available to enable easier identification of disparities. (New HOD Policy) |
| B | Res 211 | MSS | Support for Mental Health Courts | RESOLVED, That American Medical Association Policy H-100.955, “Support for Drug Courts,” be amended by addition and deletion to read as follows:Support for Mental Health ~~Drug~~ Courts, H-100.955Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system within a comprehensive system of community-based services and supports ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health ~~drug~~ courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (Modify Current HOD Policy) |
| B | Res 212  | Association for Clinical Oncology | Sequestration | RESOLVED, That our American Medical Association prioritize strong advocacy in opposition to the application of sequestration to Medicare, including to drugs administered under Medicare Part B. (Directive to Take Action) |
| B | Res 213 | Ohio | Eliminating Unfunded or Unproven Mandates and Regulations | RESOLVED, That our American Medical Association advocate for policies that allow for physician judgment and documented medical decision-making to supersede government regulation--including the utilization of Augmented Intelligence--in instances of disputes in patient care (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for policies that require “proof of concept,” in the form of independently demonstrated quality improvement, prior to the implementation of any government, insurance company or other third party mandate or regulation on patient care and the physician-patient relationship (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for policies requiring government, insurance company or other third party entities to fully fund any mandates or regulations imposed on patient care and the physician-patient relationship. (Directive to Take Action) |
| B | Res 214 | American College of Rheumatology | Stakeholder Engagement in Medicare Administrative Contractor Policy Processes | 1. RESOLVED, That our American Medical Association oppose Medicare Administrative Contractors (MACs) issuing Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes (New HOD Policy); and be it further

RESOLVED, That our AMA advocate and work with the Centers for Medicare and Medicaid Services (CMS) to ensure no LCAs that could have the effect of restricting coverage or access are issued by MACs without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input processes, through the modernization requirement of the 21st Century Cures Act (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate to CMS that the agency immediately invalidate any LCAs that it identifies as potentially restricting coverage or access and that were issued without the MACs providing public data, decision criteria, and evidentiary review, or that were issued without an associated LCD and the required stakeholder processes, and that CMS require MACs to restart those processes taking any such proposed changes through LCDs and associated requirements for stakeholder engagement, public data, and evidentiary review (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate that Congress consider clarifying legislative language that reinstates a role for local Contractor Advisory Committees in review processes going forward, addressing unintended outcomes of changes in 21st Century Cures Act that allowed local CACs to be left without a voice or purpose. (Directive to Take Action) |
| B | Res 215 | American College of Rheumatology | Pharmacy Benefit Manager Reform as a State Legislative Priority | RESOLVED, That our American Medical Association make Pharmacy Benefit Manager (PBM) reform a state legislative priority (Directive to Take Action); and be it further RESOLVED, That our AMA draft model PBM legislation or adopt model legislation from other organizations (Directive to Take Action); and be it further RESOLVED, That our AMA actively advocate for the passage of PBM reform in state legislatures across the country (Directive to Take Action); and be it further RESOLVED, That our AMA update its Health Care Reform Objectives and the AMA Vision for Health System Reform to reflect this priority change and the importance of effective PBM regulation. (Directive to Take Action)  |
| B | Res 216 | RFS | Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers | RESOLVED, That our American Medical Association reaffirm Policies H-160.947 and H‑160.950 (Reaffirm HOD Policy); and be it furtherRESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are notified in writing when their license is being used to “supervise” midlevel providers (Directive to Take Action); and be it further RESOLVED, That our AMA oppose mandatory physician supervision of midlevel providers as a condition for physician employment and in physician employment contracts, especially when physicians are not provided adequate resources and time for this responsibility (New HOD Policy); and be it furtherRESOLVED, That our AMA advocate for the right of physicians to deny “supervision” to any midlevel provider whom they deem a danger to patient safety and the ability to report unsafe care provided by mid-levels to the appropriate regulatory board with whistleblower protections for physician employment. (Directive to Take Action) |
| B | Res 217 | RFS | Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education | RESOLVED, That our American Medical Association conduct a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by physicians in field which are not a core part of those physicians’ completed residencies and fellowships. (Directive to Take Action) |
| B | Res 218 | RFS | Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care | RESOLVED, That our American Medical Association study the impact that individual physician scope of practice advocacy has had on physician employment and contract terminations (Directive to Take Action); and be it furtherRESOLVED, That our AMA study the views of patients on physician and non-physician care to identify best practices in educating the general population on the value of physician-led care (Directive to Take Action); and be it furtherRESOLVED, That our AMA study the utility of a physician-reported database to track and report institutions that replace physicians with midlevel providers in order to aid patients in seeking physician-led medical care as opposed to care by midlevel providers practicing without physician supervision. (Directive to Take Action) |
| B | Res 219 | RFS | The Impact of Midlevel Providers on Medical Education | RESOLVED, That our American Medical Association study, using surveys among other tools that protect identities, how commonly bias against physician-led healthcare is experienced within undergraduate medical education and graduate medical education, interprofessional learning and team building work and publish these findings in peer-reviewed journals (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated, and standardized education they receive (Directive to Take Action); and be it furtherRESOLVED, That our AMA study the harms and benefits of establishing mandatory postgraduate clinical training for nurse practitioners and physician assistants prior to working within a specialty or subspecialty field (Directive to Take Action); and be it furtherRESOLVED, That our AMA study the harms and benefits of establishing national requirements for structured and regulated continued education for nurse practitioners and physician assistants in order to maintain licensure to practice. (Directive to Take Action) |
| B | Res 220 | RFS | Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use | RESOLVED, That our American Medical Association oppose mandatory use of gonad shields in medical imaging considering the risks far outweigh the benefits (New HOD Policy); and be it furtherRESOLVED, That our AMA advocate that the U.S. Food and Drug Administration amend the code of federal regulations to oppose the routine use of gonad shields in medical imaging (Directive to Take Action); and be it furtherRESOLVED, That our AMA, in conjunction with state medical societies, support model state and national legislation to oppose or repeal mandatory use of gonad shields in medical imaging. (New HOD Policy) |
| B | Res 221 | Texas | Promoting Sustainability in Medicare Physician Payments | RESOLVED, That our American Medical Association continue to advocate for legislation that prevents Medicare cuts from taking place prior to Jan. 1, 2022 (Directive to Take Action); and be it furtherRESOLVED, That our AMA seek annual and full Medicare Economic Index updates for Medicare Part B physician payments (Directive to Take Action); and be it furtherRESOLVED, That our AMA seek legislation that provides only for positive performance incentives (Directive to Take Action); and be it furtherRESOLVED, That our AMA advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services by instituting a three-year look-back period to correct Medicare conversion factor estimations. (Directive to Take Action) |
| B | Res 222 | Texas | Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act | RESOLVED, That our American Medical Association oppose the U.S. Department of Health and Human Services Secretary’s Ninth Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 (the declaration); and be it furtherRESOLVED, That our American Medical Association specifically oppose expansion under the declaration of the scope of authority for state-licensed pharmacists to order and administer, and certain pharmacy technicians and pharmacy interns to administer, COVID-19 therapeutics subcutaneously, intramuscularly, or orally as authorized, approved, or licensed by the U.S. Food and Drug Administration (New HOD Policy); and be it furtherRESOLVED, That our AMA also specifically oppose the declaration as it purports to preempt state law that otherwise would prohibit these individuals from independently prescribing, dispensing, or administering COVID-19 therapeutics or other covered countermeasures (New HOD Policy); and be it furtherRESOLVED, That our AMA release a statement in opposition to the declaration and ask that it be rescinded (Directive to Take Action); and be it furtherRESOLVED, That our AMA continue to advocate for legislation that prevents the federal government from preempting state scope-of-licensure laws for physicians and health care providers. (Directive to Take Action) |
| B | Res 223 | Texas | Paying Physicians for Services According to the Physician Fee Schedule | RESOLVED, That our American Medical Association advocate for Congress to require Employee Retirement Income Security Act (ERISA) self-funded employer-sponsored plans, state-regulated plans, Medicare, Medicaid, and TRICARE to pay physicians appropriately for a covered service provided as a telemedicine service to an enrolled patient by a contracted physician at least the same as the contracted rate that would have been paid if the service were provided in an in-person setting (Directive to Take Action); and be it furtherRESOLVED, That our AMA support state medical board licensure requirements in the state where the patient is located, but otherwise the geographic and originating site restrictions should be eliminated to allow patients to receive appropriate telehealth services in their homes, residential facilities, and other locations (New HOD Policy); and be it furtherRESOLVED, That our AMA advocate that the Centers for Medicare & Medicaid Services retain on a permanent basis the telehealth services added to the Medicare telehealth services list during the public health emergency.(Directive to Take Action) |
| B | Res 224 | Florida | Improve Physician Payments | RESOLVED, That our American Medical Association make avoiding the Medicare payment cuts on physician practices a top priority (Directive to Take Action); and be it further RESOLVED, That our AMA utilize the necessary resources to avoid the pending Medicare physician payment cuts (Directive to Take Action); and be it furtherRESOLVED, That our AMA modify policy D-165.941, “Sequestration Budget Cuts,” by addition and deletion to read as follows:**Sequestration Budget Cuts D-165.941**1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.2. Our AMA will take all necessary legislative and administrative steps to prevent extended ~~or~~ and deeper sequester cuts in Medicare payments to physician practices using the financial means necessary to do so and make this a top priority. (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA reaffirm and take immediate action on policy H-330.932, “Cuts in Medicare and Medicaid Reimbursement,” that:(1) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology;(calls for elimination of budget neutrality) (current policy)(2) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (freedom of choice for patients), (current policy)(3) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; (current policy); and(4) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases. (current policy) (Reaffirm HOD Policy); and be it furtherRESOLVED, That our AMA reach out to the physicians of the United States via all possible means, to include but not be limited to email, US mail, social media, to encourage physicians to participate in the AMA campaign to improve physician payments (Directive to Take Action); and be it furtherRESOLVED, That our AMA have an open and transparent dialogue with Congressional leaders and the Centers for Medicare and Medicaid Services regarding continued devaluation of the American physician and communicate such with America’s physicians (both member and non-member). (Directive to Take Action) |
| B | Res 225 | Florida | End Budget Neutrality | RESOLVED, That our American Medical Association work towards the elimination of budget neutrality requirements under federal law (Directive to Take Action); and be it furtherRESOLVED, That our AMA amend Policy H-385.905, “Merit-based Incentive Payment System (MIPS) Update**,”** by addition and deletion to read as follows:**Merit-based Incentive Payment System (MIPS) Update H-385.905**Our AMA will work toward creating and pursuing ~~supports~~ legislation that ensures Medicare physician payments are ~~is~~ sufficient to safeguard beneficiary access to care, ~~replaces or supplements budget~~ eliminate budget neutrality requirements within the MPFS and with respect to i~~n~~ MIPS ~~with~~ incentive payments, ~~or~~ and implements ~~positive~~ annual Medicare physician payment updates that keep pace with rising practice costs. (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA reaffirm D-400.989, “Equal Pay for Equal Work,” with a special emphasis on the third bullet point and work to create legislation to eliminate budget neutrality: Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and **(3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.** (Reaffirm HOD Policy); and be it furtherRESOLVED, That our AMA reaffirm and take action on H-400.972, “Physician Payment Reform”**H-400.972, “Physician Payment Reform**It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f)the need for RBRVS conversion factor updates that are not subject to budget neutrality requirements; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures ( Reaffirmed by Rules & Credentials Cmt., A-96);(2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients;(3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system;(4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors;(5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures;(6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992;(7) seek the elimination of regulations directing patients to points of service;(8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change;(9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs;(10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes;(11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations;(12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index;(13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and(14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements. (created in 1992, reaffirmed 10 times) (Reaffirm HOD Policy) |
| B | Res 226 | Michigan | Address Adolescent Telehealth Confidentiality Concerns | RESOLVED, That our American Medical Association amend Policy H-60.965, “Confidential Health Services for Adolescents,” by addition to read as follows: Confidential Health Services for Adolescents H-60.965 Our AMA: (1) reaffirms that confidential care for adolescents is critical to improving their health; (2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law; (3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care; (4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements); (5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parent. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician; (6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis; (7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice; (8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and (9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care; and (10) encourages physicians to recognize the unique confidentiality concerns of adolescents and their parents associated with telehealth visits; and (11) encourages physicians in a telehealth setting to offer a separate examination and counseling apart from others and to ensure that the adolescent is in a private space. (Modify current HOD Policy) |
| B | Res 227 | Michigan | Medication for Opioid Use Disorder in Physician Health Programs | RESOLVED, That our American Medical Association work with stakeholders including the Federation of State Medical Boards and the Federation of State Physician Health Programs to develop guidelines supporting the adoption of policies by state-based Physician Health Programs to support individualized decision-making, inclusive of all treatment options including counseling and medication for the treatment of opioid use disorder, and considerations for safety sensitive professionals, to ensure physicians receive effective clinical care to aid in their recovery and safe and ethical return to clinical practice (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with stakeholders including the Federation of State Medical Boards and the Federation of State Physician Health Programs to develop model legislation permitting state Boards of Medicine and Osteopathic Medicine to allow for safe-haven or non‑reporting of physicians to a licensing board, and/or accept Physician Health Program compliance as an alternative to disciplinary action when public safety is not at risk, and especially for any physicians who voluntarily self-report their physical, mental, and substance use disorders and engage with a Physician Health Program and who successfully complete the terms of participation. (Directive to Take Action) |
| B | Res 228 | Michigan | Resentencing for Individuals Convicted of Marijuana-Based Offenses | RESOLVED, That our American Medical Association adopt policy supporting the expungement, destruction, or sealing of criminal records for marijuana offenses that would now be considered legal (New HOD Policy); and be it furtherRESOLVED, That our AMA adopt policy supporting the elimination of violations or other penalties for persons under parole, probation, pre-trial, or other state or local criminal supervision for a marijuana offense that would now be considered legal. (New HOD Policy) |
| B | Res 229\* | New York | CMS Administrative Requirements | RESOLVED, That our American Medical Association forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA) (Directive to Take Action); and be it furtherRESOLVED, That our AMA forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees (Directive to Take Action); and be it furtherRESOLVED, That our AMA communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans (Directive to Take Action); and be it furtherRESOLVED, That our AMA, through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment. (Directive to Take Action) |
| B | Res 230\* | New York | Medicare Advantage Plan Mandates | RESOLVED, That our American Medical Association advocate for federal legislation to ensure that no person should be mandated to change from traditional Medicare to Medicare Advantage plans. (Directive to Take Action) |
| B | Res 231\* | New York | Prohibit Ghost Guns | RESOLVED, That our American Medical Association support state and federal legislation and regulation that would subject homemade weapons to the same regulations and licensing requirements as traditional weapons. (New HOD Policy) |
| B | Res 232\* | New York | Ban the Gay/Trans (LGBTQ+) Panic Defense | RESOLVED, That our American Medical Association seek a federal law banning the use of the so-called “gay/trans (LGBTQ+) panic” defense in homicide, manslaughter, physical or sexual assault cases (Directive to Take Action); and be it furtherRESOLVED, That our AMA publish an issue brief and talking points on the topic of so called “gay/trans (LGBTQ+) panic” defense, that can be used by our AMA in seeking federal legislation, and can be used and adapted by state and specialty medical societies, other allies, and stakeholders as model legislation when seeking state legislation to ban the use of so-called “gay/trans (LGBTQ+) panic” defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide. (Directive to Take Action) |
| B | Res 233\* | New York | Insurers and Vertical Integration | RESOLVED, That our American Medical Association seek legislation and regulation to prevent health payers (except non-profit HMO’s) from owning or operating other entities in the health care supply chain. (Directive to Take Action) |
| B | Res 234\* | Illinois | Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients | RESOLVED, That our American Medical Association work with national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of dispensing stock-item medications to individual patients upon discharge in accordance with labeling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with the Food and Drug Administration, national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of using multi dose eye drop bottles post‑operatively in accordance with safe handling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste. (Directive to Take Action) |
| B | Res 235# | Aerospace Medical Association | Vital Nature of Board-Certified Physicians in Aerospace Medicine | RESOLVED, That our American Medical Association recognize the unique contributions and advanced qualifications of aerospace medicine professionals, and specifically oppose any and all efforts to remove, reduce or replace aerospace medicine physician leadership in civilian, corporate or government aerospace medicine programs and aircrew healthcare support teams; (Directive to Take Action) and be it furtherRESOLVED, That our AMA advocate for compliance with international agreements, to include advocating against other mid-level provider scope of practice expansions that threaten the safety, health, and well-being of aircrew, patients, support personnel and the flying public. (Directive to Take Action) |
| B | Res 236# | American Association of Neurological Surgeons | Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program | RESOLVED, That our American Medical Association Policy H-320.940, “Medicare’s Appropriate Use Criteria Program,” be amended by addition and deletion to read as follows: Our AMA will ~~continue to~~ advocate to Congress for ~~delay the effective date~~ either the full repeal of the Medicare Appropriate Use Criteria (AUC) Program or legislative modifications to the program in such a manner that ~~until the Centers for Medicare & Medicaid Services (CMS) can~~ adequately addresses technical and workflow challenges, ~~with its implementation and any interaction between~~ maximizes alignment with the Quality Payment Program (QPP), and ~~the use of advanced diagnostic imaging appropriate use criteria.~~ creates provider flexibility for the consultation of AUC or advanced diagnostic imaging guidelines using a mechanism best suited for their practice, specialty and workflow. (Modify Current HOD Policy) |
| B | Res 237# | Georgia | Universal Good Samaritan Statute | RESOLVED, That our American Medical Association help protect patients in need of emergency care and protect physicians and other responders by advocating for a national “universal” Good Samaritan Statute (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for the unification of the disparate statutes by creation of a national standard via either federal legislation or through policy directed by the Department of Health and Human Services (HHS) to specify terms that would protect rescuers from legal repercussion as long as the act by the rescuer meets the specified universal minimal standard of conduct and the good faith requirement, regardless of the event location; thus, effectively eliminating variations in the state statutes to facilitate the intent of the Good Samaritan statutes removing barriers that could impede the prompt rendering of emergency care. (Directive to Take Action) |
| B | Res 238# | Pennsylvania | Increasing Residency Positions for Primary Care | RESOLVED, That our American Medical Association prioritize the number of accredited residency positions, with the goal to increase the overall number especially in specialties deemed primary care (Directive to Take Action); and be it furtherRESOLVED, That our AMA seek to increase the cap of Medicare support for graduate medical education. (Directive to Take Action) |
| B | Res 239# | Pennsylvania | Making State Health Care Cost Containment Datasets Free of Cost and Readily | RESOLVED, That our American Medical Association advocate for affordable and open access to all all-payer claims databases (APCDs) data for academic research purposes. (Directive to Take Action) |
| B | Res 240# | OMSS | Ransomware Prevention and Recovery | RESOLVED, That our American Medical Association work with other stakeholders to seek legislation or regulation that funds assistance to cover cyberattack prevention and recovery expenses for physician practices, hospitals, and healthcare entities to ensure continuity of optimal patient care (Directive to Take Action); and be it furtherRESOLVED, That our AMA, in collaboration with appropriate stakeholders, develop a toolkit for physician practices, hospitals, and healthcare entities to include best practices on preventing cyberattacks and a plan of action for when such an attack happens to their practice or institution; the toolkit should include guides to financial resources. (Directive to Take Action) |
| B | Res 241# | PPPS | Enforcement of Administrative Simplification Requirements - CMS | RESOLVED, That our American Medical Association take the position that the failure by the National Standards Group at the Centers for Medicare and Medicaid Services Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans is clearly unacceptable (New HOD Policy); and be it furtherRESOLVED, That our AMA take the position that the National Standards Group at the Centers for Medicare and Medicaid Services Office of Burden Reduction practices of closing complaints without further investigation and ignoring overwhelming evidence that contradicts health plan assertions is also unacceptable (New HOD Policy); and be it furtherRESOLVED, That our American Medical Association advocate for enhanced enforcement of the HIPAA Administrative Simplification requirements for health plans. (Directive to Take Action) |
| C | CME 01 | n/a | Guiding Principles and Appropriate Criteria for Assessing the Competency of Late Career Physicians | 1. That our American Medical Association (AMA) support the following Guiding Principles on the Assessment of Late Career Physicians:
2. Evidence-based: Guidelines for assessing and screening late career physicians should be based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Some physicians may suffer from declines in practice performance with advancing age. Research also suggests that the effect of age on an individual physician’s competency can be highly variable; and since wide variations are seen in cognitive performance with aging, age alone should not be a precipitating factor.
3. Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues’ competency.
4. Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians’ ability to perform the tasks specifically required in their practice environment.
5. Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results.
6. Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to a physician’s practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care.
7. Transparent: Guidelines, procedures, or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations, and standards against which performance will be judged and the possible outcomes of the screening or assessment.
8. Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive.
9. Cost conscious: Procedures and screening mechanisms that are distinctly different from “for cause” assessments should not result in undue cost or burden to late career physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed late career physicians. Similar procedures and screening mechanisms should be available to late career physicians who are not employed by hospitals and health care systems. (Directive to Take Action)
10. That our AMA encourage the Council of Medical Specialty Societies and other interested organizations to develop educational materials on the effects of age on physician practice. (Directive to Take Action)
11. That Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)
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| C | CME 02 | n/a | A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities | 1. That our American Medical Association (AMA) urge that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing “organic” standards with “functional” standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites. (Directive to Take Action)
2. That our AMA urge all medical schools and GME institutions to a) make available to students and trainees a designated, qualified person or committee knowledgeable of the Americans with Disabilities Act and available support services and b) encourage students and trainees to avail themselves of support services. (Directive to Take Action)
3. That our AMA encourage the National Board of Medical Examiners and National Board of Osteopathic Medical Examiners to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of the USMLE and COMLEX, including an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. (Directive to Take Action)
4. That our AMA encourage research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice. (Directive to Take Action)
5. That our AMA rescind Policy D-295.929, “A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities,” as having been fulfilled by this report. (Rescind HOD Policy)
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| C | CME 03 | n/a | Rural Health Physician Workforce Disparities | 1. That our AMA amend Policy H-465.988, “Educational Strategies for Meeting Rural Health Physician Shortage,” by addition and deletion to read as follows: ~~Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.~~ (4) Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas. (5) Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs. (Modify Current HOD Policy)
2. That our AMA monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities. (Directive to Take Action)
3. That our AMA amend Policy H-200.954, “US Physician Shortage,” by addition to read as follows: “(13) will monitor the impact of initiatives to address rural physician workforce shortages.” (Modify Current HOD Policy)
4. That our AMA reaffirm Policy H-465.988, “Educational Strategies for Meeting Rural Health Physician Shortage,” which states, in part “(1.a) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents. (1.b) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.” (Reaffirm HOD Policy).
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| C | CME 04 | n/a | Medical Student Debt and Career Choice | 1. That our American Medical Association (AMA) encourage key stakeholders to collect and disseminate data on the impacts of medical education debt on career choice, especially with regard to the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors. (New HOD Policy)
2. That our AMA monitor new policies and novel approaches to influence career choice based on the key factors that affect the decision to enter a given specialty and subspecialty. (New HOD Policy)
3. That our AMA amend Policy H-305.925 (20), “Principles of and Actions to Address Medical Education Costs and Student Debt,” by addition and deletion, to read as follows:

“Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician ~~benefits~~ participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer’s PSLF program qualifying status ~~of the employer~~; (f) Advocate that the profit status of a physician’s training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; and (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unacceptably high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program.” (Modify Current HOD Policy)1. That our AMA rescind Policy H-305.925 (22), “Principles of and Actions to Address Medical Education Costs and Student Debt,” as having been fulfilled through this report:

“~~Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice~~.” (Rescind HOD Policy) |
| C | CME 05 | n/a | Investigation of Existing Barriers for Osteopathic Medical Students Applying for Away Rotations | 1. That our American Medical Association (AMA) amend Policy H-295.876 (2), “Equal Fees for Osteopathic and Allopathic Medical Students,” by addition and deletion as shown below. (Modify Current HOD Policy)

Our AMA encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students ~~in access to clinical electives~~, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.1. That our AMA encourage the Association of American Medical Colleges to request that its member institutions promote equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (New HOD Policy)
2. That our AMA encourage the Accreditation Council for Graduate Medical Education to require its accredited programs to work with their respective affiliated institutions to ensure equitable access to clinical electives for allopathic and osteopathic medical students and charge equitable fees to visiting allopathic and osteopathic medical students. (New HOD Policy)
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| C | Res 301 | MSS | Equitable Reporting of USMLE Step 1 Scores | RESOLVED, That our American Medical Association work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination Level 1 scores and students who received Pass/Fail scores. (Directive to Take Action) |
| C | Res 302 | MSS | University Land Grant Status in Medical School Admissions | RESOLVED, That our American Medical Association work with the Association of American Medical Colleges, Liaison Committee on Medical Education, Association of American Indian Physicians, and Association of Native American Medical Students to design and promulgate medical school admissions recommendations in line with the federal trust responsibility (Directive to Take Action); and be it further RESOLVED, That our AMA amend Policy H-350.981, “AMA Support of American Indian Health Career Opportunities,” by addition to read as follows:AMA Support of American Indian Health Career Opportunities H-350.981AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees.(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population.(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.(5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.(6) Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI-AN communities. (Modify Current HOD Policy) |
| C | Res 303 | MSS | Decreasing Bias in Evaluations of Medical Student Performance | RESOLVED, That our American Medical Association work with appropriate stakeholders, such as the Liaison Committee on Medical Education and the Commission on Osteopathic College Accreditation to support: 1) increased diversity and implementation of implicit bias training to individuals responsible for assessing medical students’ performance, including the evaluation of professionalism and investigating and ruling upon disciplinary matters involving medical students; and 2) that all reviews of medical student professionalism and academic performance be conducted in a blinded manner when doing such does not interfere with appropriate scoring (Directive to Take Action); and be it furtherRESOLVED, That our AMA study the impact of two-interval clinical clerkship grading systems on residency application outcomes and clinical performance during residency. (Directive to Take Action) |
| C | Res 304 | MSS | Reducing Complexity in the Public Service Loan Forgiveness Program | RESOLVED, That our American Medical Association amend Policy H-305.925, “Principles of and Actions to Address Medical Education Costs and Student Debt,” by addition to read as follows:H-305.925 Principles of and Actions to Address Medical Education Costs and Student DebtThe costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Work with the United States Department of Education to ensure that applicants of the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; (c) Work with the United States Department of Education to ensure individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s) due to bureaucratic complexities; (~~b~~d) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (~~c~~e) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (~~d~~f) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (~~e~~g) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (~~f~~h) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (~~g~~i) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (~~h~~j) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (~~i~~k) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.
23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education. (Modify Current HOD Policy)
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| C | Res 305 | MSS | Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status | RESOLVED, That our American Medical Association issue an official public statement regarding the academic status of Puerto Rican medical students and schools to inform residency, fellowship, and academic programs in the continental United States that all medical schools from Puerto Rico are Liaison Committee on Medical Education (LCME), Association of American Medical Colleges (AAMC), and Middle States Commission on Higher Education (MSCHE) accredited, and their medical students are not considered international medical graduates (Directive to Take Action); and be it furtherRESOLVED, That our AMA support policies that ensure equity and parity in the undergraduate and graduate educational and professional opportunities available to medical students and graduates from Puerto Rican medical schools. (New HOD Policy) |
| C | Res 306 | MSS | Support for Standardized Interpreter Training | RESOLVED, That our American Medical Association recognize the importance of using medical interpreters as a means of improving quality of care provided to patients with Limited English Proficiency (LEP) including patients with sensory impairments (New HOD Policy); andRESOLVED, That our AMA encourage physicians and physicians in training to improve interpreter-use skills and increase education through publicly available resources such as the American Association of Medical College’s “Guidelines for Use of Medical Interpreter Services” (New HOD Policy); and be it furtherRESOLVED, That our AMA work with the Commission for Medical Interpreter Education, National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians, National Medical Association, Association of American Indian Physicians, and other relevant stakeholders to develop a cohesive Continuing Medical Education module offered through the AMA Ed Hub for physicians to effectively and appropriately use interpreter services to ensure optimal patient care. (Directive to Take Action) |
| C | Res 307 | MSS | Support for Institutional Policies for Personal Days for Undergraduate Medical Students | RESOLVED, That our American Medical Association encourage medical schools to accept flexible uses for excused absences from clinical clerkships (New HOD Policy); and be it furtherRESOLVED, That our AMA support a clearly defined number of easily accessible personal days for medical students per academic year, which should be explained to students at the beginning of each academic year and a subset of which should be granted without requiring an explanation on the part of the students. (New HOD Policy) |
| C | Res 308 | MSS | Modifying Eligibility Criteria for the Association of American Medical Colleges’ Financial Assistance Program | RESOLVED, That our American Medical Association encourage the Association of American Medical Colleges to conduct a study of the financial impact of the current Fee Assistance Program policy to medical school applicants. (New HOD Policy) |
| C | Res 309 | MSS | Protecting Medical Student Access to Abortion Education and Training | RESOLVED, That our American Medical Association amend policy H-295.923, “Medical Training and Termination of Pregnancy,” by addition and deletion to read as follows:H-295.923 – MEDICAL TRAINING AND TERMINATION OF PREGNANCY1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.2.~~,~~ ~~a~~ Although observation of, attendance at, or any direct or indirect participation in ~~an~~ abortion procedures should not be required~~.~~, our AMA does support opt-out curriculum on abortion education. Further, the AMA supports the opportunity for medical students and residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.~~2~~3. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists’ recommendations. (Modify Current HOD Policy) |
| C | Res 310 | RFS | Resident and Fellow Access to Fertility Preservation | RESOLVED, That our American Medical Association support education for residents and fellows regarding the natural course of female fertility in relation to the timing of medical education, and the option of fertility preservation and infertility treatment (New HOD Policy); and be it further RESOLVED, That our AMA advocate inclusion of insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs (Directive to Take Action); and be it furtherRESOLVED, That our AMA support the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including the need to attend medical visits to complete the oocyte preservation process and to administer medications in a time-sensitive fashion. (New HOD Policy) |
| C | Res 311 | RFS | Improving Access to Physician Health Programs for Physician Trainees | RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education and other relevant stakeholders to ensure physician health programs (PHPs) are promoted by training programs and transparent information is disseminated by programs to their trainees about PHP reporting requirements, benefits of participation, and limitations of such programs (Directive to Take Action); and be it furtherRESOLVED, That our AMA recognize PHPs as one of many resources available to support physician trainee mental health. (New HOD Policy) |
| C | Res 312 | RFS | Accountable Organizations to Resident and Fellow Trainees | RESOLVED, That our American Medical Association work with relevant stakeholders to: (1) determine which organizations or governmental entities are best suited for being permanently responsible for resident and fellow interests without conflicts of interests; (2) determine how organizations can be held accountable for fulfilling their duties to protect the rights and wellbeing of resident and fellow trainees as detailed in the Residents and Fellows’ Bill of Rights; (3) determine methods of advocating for residents and fellows that are timely and effective without jeopardizing trainees’ current and future employability; (4) study and report back by the 2022 Annual Meeting on how such an organization may be created, in the event that no organizations or entities are identified that meet the above criteria; and (5) determine transparent methods to communicate available residency positions to displaced residents. (Directive to Take Action) |
| C | Res 313 | RFS | Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training | RESOLVED, That our American Medical Association support current efforts by the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and other relevant stakeholders to develop and align minimum requirements for parental leave during residency and fellowship training and urge these bodies to adopt minimum requirements in accordance with policy H-405.960 (New HOD Policy); and be it furtherRESOLVED, That our AMA petition the ACGME to recommend strategies to prevent undue burden on trainees related to parental leave; (Directive to Take Action)RESOLVED, That our AMA petition the ACGME, ABMS, and other relevant stakeholders to develop specialty specific pathways for residents and fellows in good standing, who take maximum allowable parental leave, to complete their training within the original time frame. (Directive to Take Action) |
| C | Res 314 | RFS | Updating Current Wellness Policies and Improving Implementation | RESOLVED, That our American Medical Association work with the Accreditation Council on Graduate Medical Education and other appropriate stakeholders in the creation of an evidence-based best practices reference to address trainee burnout prevention and mitigation. (Directive to Take Action) |
| C | Res 315 | RFS | Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc., Equitable for IMGS | RESOLVED, That our American Medical Association work with all relevant stakeholders to reduce application, exam, licensing fees and related financial burdens for IMGs to ensure cost equity with US MD and DO trainees (Directive to Take Action); and be it furtherRESOLVED, That our AMA amend current policy H-255.966, “Abolish Discrimination in Licensure of IMGs,” by addition to read as follows:2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements, and associated costs, for all physicians, whether U.S. medical school graduates or international medical graduates. (Modify Current HOD Policy) |
| C | Res 316\* | New York | Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic | RESOLVED, That our American Medical Association study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students, physicians in training, and early career physicians. (Directive to Take Action) |
| C | Res 317\* | Illinois | Creating a More Accurate Accounting of Medical Education Financial Costs | RESOLVED, That our American Medical Association study the costs of medical education, taking into account medical student tuition and accrued loan interest, to come up with a more accurate description of medical education financial costs. (Directive to Take Action) |
| C | Res 318# REVISED  | North Carolina | The Medical Student Match MisMatch (REVISED) | RESOLVED, That our American Medical Association use its existing resources or find new ones to: (1) help educate rising senior US medical students on how to have a successful match; (2) give real time help to US medical students, including international medical graduates, to navigate post matching results; (3) help unmatched US medical students and international medical graduates navigate loan repayment strategies; and (4) guide the unmatched towards alterative professional options in medical or public or commercial sectors (Directive to Take Action); and be it further RESOLVED, That the assigned AMA staff engage with AMA legal and AMA advocacy staff to redouble AMA efforts legislatively or otherwise, to increase and fund the additional graduate medical education slots. (Directive to Take Action) |
| D | BOT 17 | n/a | Distracted Driver Education and Advocacy | The Board of Trustees recommends that Policy H-15.952 be amended by addition and deletion to read as follows and the remainder of the report be filed.H-15.952, “The Dangers of Distraction While Operating Hand-Held Devices”1. Our AMA encourages physicians to educate their patients regarding the public health risks of ~~text messaging while operating motor vehicles or machinery~~ distracted driving, which includes the risks of visual distraction – taking one’s eyes off the road, manual distraction – taking one’s hands off the wheel, and cognitive distraction – taking one’s mind off what he or she doing. ~~and will advocate for state legislation prohibiting the use of handheld communication devices~~ ~~to text message~~ ~~while operating motor vehicles or machinery~~.2. Our AMA will: (a) ~~endorse~~ support legislation that would ban the use of hand-held devices while driving, as a step in the right direction towards preventing distracted driving and (b) encourage additional research to identify the most effective strategies to reduce distracted driving-related crash risks.3. Our AMA: (a) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (b) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.5. Our AMA: (a) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (b) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.6. Our AMA will: (a) make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with ~~the Centers for Disease Control and Prevention and other~~ interested stakeholders~~; and (b) explore developing an advertising campaign~~ ~~on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting~~.~~7. Our AMA will escalate the distracted driving campaign to a national level of awareness in coordination with the CDC and the National Education Association to educate elementary up through high school students as well as parents regarding the high-risk behavior of driving while holding cell phones and the opportunity to save lives and avoid injuries, with a review of steps taken and report back to the House of Delegates at the 2020 Annual Meeting.~~ |
| D | CSAPH 02 | n/a | Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems | 1. That Policy D-440.922, “Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems” be amended by addition and deletion to read as follows:

Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; ~~and (2) study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending~~ (2) develop an organization-wide strategy on public health including ways in which the AMA can ~~to~~ strengthen the health and public health system infrastructure and report back as needed on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs. (Modify Current AMA Policy)1. That Policy H-440.960, “Organized Medicine and Public Health Collaboration” be amended by addition and deletion to read as follows:

Our AMA (1) encourages medical societies to establish liaison committees through which physicians in private practice and officials in public health can explore issues and mutual concerns involving public health activities and private practice; (2) seeks increased dialogue, interchange, and cooperation among national organizations representing public health professionals, including representatives from governmental public health, and those representing physicians in private practice or those employed in health systems and in academic medicine (3) actively supports promoting and contributing to increased attention to public health issues in its programs in medical science and education; ~~(4) continues to support the providing of medical care to poor and indigent persons through the private sector and the financing of this care through an improved Medicaid program;~~ (~~54~~) encourages public health agencies to focus on assessment of problems, assurance of healthy living conditions, policy development, and other related activities; ~~and~~ (~~6~~5) encourages physicians in private practice and those in public health to work cooperatively, striving to ensure better health for each person and an improved community as enjoined in the Principles of Medical Ethics; and (6) encourages state and local health agencies to communicate directly with physicians licensed in their jurisdiction about the status of the population’s health, the health needs of the community, and opportunities to collectively strengthen and improve the health of the public. (Modify Current AMA Policy)3. That AMA Policy H-440.912, “Federal Block Grants and Public Health” which calls on the AMA to collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated and urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; be reaffirmed. (Reaffirm Current AMA Policy)4. That AMA Policy H-440.989, “Continuation of the Commissioned Corps,” be amended by addition to read as follows:Our AMA strongly supports the expansion and continuation of the Commissioned Corps of the US Public Health Service and recognize the need for it to be adequately funded. (Modify Current AMA Policy)5. That our AMA reaffirm Policies D-305.964, “Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion,” and D-295.327, “Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum.” (Reaffirm Current AMA Policy)6. That our AMA reaffirm Policy H-440.89, “Support of the National Laboratory Response Network,” and Policy D-460.971, “Genome Analysis and Variant Identification.” (Reaffirm Current AMA Policy)7. That our AMA amend Policy H-440.813, “Public Health Surveillance” by addition and deletion to read as follows:Our AMA: (1) recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats; (2) recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities; (3) encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health; (4) recognizes the need for increased federal, state, and local funding to modernize our nation’s public health data systems to improve the quality and timeliness of data; (5) supports the CDC’s data modernization initiative, including electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws; (6) will advocate for incentives for physicians to upgrade their EHR systems to support electronic case reporting as well as incentives to submit case reports that are timely and complete; (~~6~~7) will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting; (~~7~~8~~)~~ will advocate for increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments; ~~and~~ (~~8~~9) supports data standardization that provides for minimum national standards, while preserving the ability of states and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations. (Modify Current AMA Policy) |
| D | CSAPH 03 | n/a | Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury | 1. Our AMA encourages research on cognitive impairment, including traumatic brain injury (TBI), as a risk factor for driving and/or firearm ownership, and the role of the physician in preventing morbidity and mortality (New HOD Policy).
2. That Policy H-15.995, “Medical Advisory Boards in Driver Licensing,” advocating for state governments to create and maintain medical advisory boards to oversee driver licensing, be reaffirmed. (Reaffirm Current HOD Policy)
3. That Policy H-145.972, “Firearms and High-Risk Individuals,” which advocates for ERPO laws and protocols for removing firearms from those deemed to be high-risk in the wake of a petition from concerned parties, be reaffirmed. (Reaffirm Current HOD Policy)
4. That Policy H-145.970, “Violence Prevention,” calling upon state and federal government entities to strengthen and promote the use of the NICS background check system, be reaffirmed. (Reaffirm Current HOD Policy)
5. That Policy H-145.976, “Firearm Safety Counseling in Physician-Led Health Care Teams,” which protects the right of a physician to counsel a patient and/or their family about the risks of gun ownership and appropriate safety measures, be reaffirmed. (Reaffirm Current HOD Policy)
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| D | Res 401 | SPS | Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post Acute Covid Syndrome | RESOLVED, That our American Medical Association through its advocacy and public relations divisions promote and support all public health recommendations relating to the Covid-19 emergency that are consistent with sound scientific principles and law, and not inconsistent with evolving AMA policy (Directive to Take Action); and be it furtherRESOLVED, That our AMA promote and encourage through all available means the further investigation of PACS, and third-party support for evaluation and care of COVID-19 long-hauler patients. (Directive to Take Action) |
| D | Res 402 | MSS | Expansion on Comprehensive Sexual Health Education | RESOLVED, That our American Medical Association amend Policy H-170.968, “Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools,” by addition and deletion to read as follows:Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools, H-170.968(1) ~~Recognizes that the primary responsibility for family life education is in the home, and additionally~~ ~~s~~ Supports the concept of a ~~complementary~~ family life and sexuality education program in the schools at all levels, at local option and direction;(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms dental dams, and other barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ ~~gay, lesbian, and bisexual~~ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;(6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;(7) Supports federal funding of comprehensive sex education programs that stress the importance of ~~abstinence in~~ preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, ~~and also teach about~~ including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and(8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;(9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and(10) Encourages physicians and all interested parties to ~~conduct research and~~ develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate. (Modify Current HOD Policy) |
| D | Res 403 | MSS | Providing Reduced Parking for Patients | RESOLVED, That our American Medical Association work with relevant stakeholders to recognize parking fees as a burden of care for patients and to implement mechanisms for reducing parking costs. (Directive to Take Action) |
| D | Res 404 | MSS | Increase Employment Services Funding for People with Disabilities | RESOLVED, That our American Medical Association support increased resources for employment services to reduce health disparities for people with disabilities. (New HOD Policy) |
| D | Res 405 | MSS | Formal Transitional Care Program for Children and Youth with Special Health Care Needs | RESOLVED, That our American Medical Association amend Policy H-60.974, “Children and Youth with Disabilities,” by addition and deletion to read as follows, to strengthen our AMA policy and to include a population of patients that do not fall under “disability” but also need extra care, especially when transitioning to adult health care, that they are currently not receiving due to a gap: H-60.974: CHILDREN AND YOUTH WITH DISABILITIES AND WITH SPECIAL HEALTH CARE NEEDSIt is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities and children and youth with special health care needs (CYSHCN);(2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted;(3) to encourage physicians to provide services to children and youth with disabilities and CYSHCN that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child;(4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities and CYSHCN receive appropriate school health services;(5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities, ~~and~~ CYSHCN, and their families to plan and make the transition to the adult medical care system;(6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and(7) to encourage physicians to make their offices accessible to patients with disabilities and CYSHCN, especially when doing office construction and renovations. (Modify Current HOD Policy) |
| D | Res 406 | RFS | Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer | RESOLVED, That our American Medical Association amend current policy H-440.872 “HPV Vaccine and Cervical Cancer Prevention Worldwide,” by addition and deletion to read as follows:1. Our AMA (a) urges physicians to educate themselves and their patients about all HPV-mediated ~~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 all HPV-mediated ~~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, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
4. Our AMA supports efforts (a) to enhance awareness in the general public regarding the association between HPV infection and oropharyngeal squamous cell carcinoma, and (b) to further develop oropharyngeal squamous cell carcinoma screening tools. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend current policy H-440.872 “HPV Vaccine and Cervical Cancer Prevention Worldwide” by title change to “HPV Vaccine and ~~Cervical~~ HPV-mediated Cancer Prevention Worldwide”; (Modify Current HOD Policy) and be it furtherRESOLVED, That our AMA reaffirm Policies D-170.995 “Human Papillomavirus (HPV) Inclusion in our School Education Curricula,” and D-440.955 “Insurance Coverage for HPV Vaccine.” (Reaffirm HOD Policy) |
| D | Res 407 | RFS | Traumatic Brain Injury and Access to Firearms | RESOLVED, That our American Medical Association reaffirm Policy H-145.972, “Firearms and High-Risk Individuals” (Reaffirm HOD Policy); and be it furtherRESOLVED, That our AMA amend Policy H-145.975 “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” by addition and deletion to read as follows: …2. Our AMA supports initiatives designed to enhance access to the comprehensive assessment and treatment of mental ~~illness~~ health and ~~concurrent~~ substance use disorders~~,~~ in patients with traumatic brain injuries, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior. 3. Our AMA work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to evaluate the risk of potential violent behavior in patients with traumatic brain injuries.~~3.~~ 4. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide. (Modify Current HOD Policy) |
| D | Res 408\* | New York | Ensuring Affordability and Equity in COVID-19 Vaccine Boosters | RESOLVED, That our American Medical Association support the public purchase and cost-free distribution of COVID-19 booster vaccine doses. (New HOD Policy) |
| D | Res 409# | Pennsylvania | Screening for HPV-Related Anal Cancer | RESOLVED, That our American Medical Association support advocacy efforts to implement screening for anal cancer for high-risk populations (New HOD Policy); and be it furtherRESOLVED, That our AMA support national medical specialty organizations and other stakeholders in developing guidelines for interpretation, follow up, and management of anal cancer screening results. (New HOD Policy) |
| D | Res 410# | RFS | Affirmatively Protecting the Safety and Dignity of Physicians and Medical Students as Workers | RESOLVED, That our American Medical Association review reports of unsafe working conditions and unfair retaliation for public expression of safety concerns on the part of physicians and trainees and consider methods to provide logistical and legal support to such aggrieved parties (Directive to Take Action); and be it furtherRESOLVED, That our AMA develop and distribute specific guidelines on how physicians and trainees may make public comments on working conditions and legal options to promote workplace safety (e.g. filing formal OSHA complaints), as well as other workplace protection issues as appropriate (Directive to Take Action); and be it furtherRESOLVED, That AMA policy H-440.810, “Availability of PPE,” be amended by addition to read as follows:1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.3. Our AMA will AMA advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.5. Our AMA supports a physician’s right to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster; resident physicians and medical students must have the right to participate in public commentary addressing the adequacy of resources for their own safety in such conditions. 6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA support the inclusion of health care workers in workplace protections and programs generally applicable to employees in other sectors, barring extenuating circumstances and evidence-based reasoning supporting otherwise (New HOD Policy); and be it furtherRESOLVED, That our AMA support legislation and other policies protecting physicians and medical students from violence and unsafe working conditions. (New HOD Policy) |
| D | Res 411# | YPS | Addressing Public Health Disinformation | RESOLVED, That our American Medical Association collaborate with relevant stakeholders on efforts to combat public health disinformation on all forms of media. (Directive to Take Action) |
| D | Res 412# | YPS | Health Professional Disinformation During a Public Health Crisis | RESOLVED, That our American Medical Association work with health professional societies to address disinformation that undermines public health initiatives. (Directive to Take Action) |
| D | Res 413# | MSS | Universal Childcare and Preschool | RESOLVED, That our American Medical Association advocate for universal access to high-quality and affordable childcare and preschool. (Directive to Take Action) |
| D | Res 414# | MSS | Advocacy on the US Department of Education’s Spring 2022 Title IX Rule on Sexual Harassment and Assault in Education Programs | RESOLVED, That our American Medical Association work with relevant stakeholders to release a statement and advocate that the US Department of Education replace their 2020 Title IX rule on sexual harassment and assault in educational settings, including undergraduate and graduate medical education, with a comprehensive rule that preserves the safety and wellbeing of all people affected by sexual assault. (Directive to Take Action) |
| D | Res 415 | MSS | Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV | RESOLVED, That our American Medical Association amend Policy H-20.895 “Pre-Exposure Prophylaxis (PrEP) for HIV,” by addition to read as follows:Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.8951. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling, regardless of a patient’s current reported sexual behaviors. (Modify Current HOD Policy) |
| E | CSAPH 04 | n/a | Pharmacovigilance | 1. That Policy D-100.988, “Tracking and Punishing Distributors of Counterfeit Pharmaceuticals” be amended by addition and deletion to read as follows:

Our AMA will support the Food and Drug Administration's efforts to evaluate and facilitate implementation of effective tracking systems for pharmaceuticals~~.~~, including all outlined implementation phases of the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54) also called “track and trace,” which contains extensive requirements and provisions related to supply chain participants and regulated products. (Modify Current HOD Policy)1. That Policy H-120.958, “Supporting Safe Medical Products as a Priority Public Health Initiative” be amended by addition and deletion to read as follows:

Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names;(2) continue participation in ~~the National Patient Safety Foundation's~~ efforts to advance the science of safety in the medication use process, including ~~and likewise~~ work with the National Coordinating Council for Medication Error Reporting and Prevention;(3) support the FDA’s Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events;(4) vigorously work to support the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54), including provisions on product identification and verification, data sharing, detection and response, ~~and encourage efforts to create and expeditiously implement a national machine-readable coding system for prescription medicine packaging~~ in an effort to improve patient safety;(5) participate in and report on the work of the Healthy People ~~2010~~ 2030 initiative in the area of safe medical products especially as it relates to existing AMA policy; and(6) seek opportunities to work collaboratively within the Medicine-Public Health initiative (H‑440.991) and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for ~~Health Care Policy and Research (AHCPR)~~ Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety. (Modify Current HOD Policy)1. That Policy D-100.977, “Pharmaceutical Quality Control for Foreign Medications,” that calls upon Congress to provide the FDA with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients, be reaffirmed. (Reaffirm HOD Policy)
2. That Policy D-100.985, “Federal Regulation and Computerized Tracking of Pharmaceuticals During Shipping and Handling from Manufacture Until Ultimately Received by Patient,” opposing illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting, be reaffirmed. (Reaffirm HOD Policy)
3. That Policy D-100.988, “Tracking and Punishing Distributors of Counterfeit Pharmaceuticals,” supporting the FDA’s efforts to evaluate and facilitate implementation of effective tracking systems for pharmaceuticals, be reaffirmed. (Reaffirm HOD Policy)
4. That Policy H-100.946, “Source and Quality of Medications Critical to National Health and Security,” supporting legislative and regulatory initiatives that help to ensure proper domestic capacity, production and quality of pharmaceutical and chemical substrates as a matter of public well-being and national security and encouraging the development and enforcement of standards that make the sources of pharmaceuticals and their chemical substrates used in the United States of America transparent to prescribers and the general public, be reaffirmed. (Reaffirm HOD Policy)
5. That Policy H-100.969, “Assuring the Safety and Quality of Foreign-Produced Pharmaceuticals,” supporting the inspection of all foreign manufacturers of pharmaceutical chemicals and products which are exported to the United States to assure compliance with U.S. standards, be reaffirmed. (Reaffirm HOD Policy)
6. That Policy H-100.995, “Support of American Drug Industry,” supporting the American pharmaceutical manufacturing industry in its efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit of the American people, be reaffirmed. (Reaffirm HOD Policy)
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| E | Res 501 | Washington | Ensuring Continued Access to Equitable Take-Home Methadone Treatment | RESOLVED, That our American Medical Association support increasing the interval between take-home methadone distributions for maintenance and detoxification treatment, per provider discretion; this may include policy similar to the COVID-era extension policy created by the Substance Abuse and Mental Health Services Administration (SAMHSA) (New HOD Policy); and be it furtherRESOLVED, That our AMA utilize the “Good Guidance” petition process to request SAMHSA modify current policy to reflect the COVID-19 era policy on take-home methadone doses. (Directive to Take Action) |
| E | Res 502 | Washington | Advocating for Heat Exposure Protections for Outdoor Workers | RESOLVED, That our American Medical Association advocate for outdoor workers to have access to preventative cool-down rest periods in shaded areas for prevention of heat exhaustion and health educational materials in their primary language (Directive to Take Action); and be it furtherRESOLVED, That our AMA support legislation creating federal standards for protections against heat stress specific to the hazards of the workplace including appropriate access to emergency services at signs and symptoms of heat exposure injury (New HOD Policy); and be it furtherRESOLVED, That our AMA work with the United States Department of Labor, the Occupational Safety and Health Administration, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for outdoor workers independent of legal status. (Directive to Take Action) |
| E | Res 503 | YPS | Marketing Guardrails for the “Over-Medicalization” of Cannabis Use | RESOLVED, That our American Medical Association send a formal letter to the Food and Drug Administration and Federal Trade Commission requesting more direct oversight of the marketing of cannabis for medical use. (Directive to Take Action) |
| E | Res 504 | New England | Air Pollution and COVID: A Call to Tighten Regulatory Standards | RESOLVED, That our American Medical Association advocate for stronger federal particulate matter air quality standards and improved enforcement that will better protect the public’s health. (Directive to Take Action) |
| E | Res 505 | MSS | Representation of Dermatological Pathologies in Varying Skin Tones | RESOLVED, That our American Medical Association encourage the inclusion of a diverse range of skin tones in preclinical and clinical dermatologic medical education materials and evaluation (New HOD Policy); and be it furtherRESOLVED, That our AMA encourage the development of educational materials for medical students and physicians that contribute to the equitable representation of diverse skin tones (New HOD Policy); and be it further RESOLVED, That our AMA support the overrepresentation of darker skin tones in dermatologic medical education materials. (New HOD Policy) |
| E | Res 506 | MSS | Enhancing Harm Reduction for People Who Use Drugs | RESOLVED, That our American Medical Association amend Policy D-95.987, “Prevention of Opioid Overdose,” by addition and deletion as follows: D-95.987 – PREVENTION OF ~~OPIOID~~ DRUG-RELATED OVERDOSE1. Our AMA: (A) recognizes the great burden that ~~opioid addiction and prescription drug abuse~~ 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 ~~such~~ 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 implemented in order to further develop best practices in this area; ~~and~~ (C) encourages the education of health care workers and people who use drugs ~~opioid users~~ 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 ~~opioid~~ a drug-related overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for ~~opioid~~ 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 ~~opioid addiction~~ a SUD and their friends/families that address harm reduction measures ~~how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death~~.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 to support safe use of drugs, including drug contamination testing and injection drug preparation, use, and disposal supplies. (Modify Current HOD Policy) |
| E | Res 507# | Delaware | Healthy Air Quality | RESOLVED, That our American Medical Association work with the Office of Climate Change and Health Equity to champion legislation and policies at the federal level in order to drive down the generation of PM 2.5 and other pollutants by: 1. Shifting our energy generation away from polluting sources like fossil fuels and toward less polluting renewables; and
2. Shifting our agricultural practices away from traditional industrial practices like the use of excessive nitrate fertilizers and toward regenerative practices; and
3. Shifting other industries toward proper capture and disposal of waste to minimize the release of fine particulate pollution. (Directive to Take Action)
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| E | Res 508# | Pennsylvania | Personal Care Products Safety | RESOLVED, That our American Medical Association advocate that the Food and Drug Administration (FDA) be given the appropriate resources and authority to effectively regulate and enforce standards for personal care products, including being authorized to mandate registration and reporting by manufacturers, conduct appropriate inspections of manufacturing facilities, ensure robust review of product safety, and require adherence with Good Manufacturing Practices while allowing flexibility for small business to comply; and reaffirm support for providing the FDA with sufficient authority to recall cosmetic products that it deems to be harmful. (Directive to Take Action) |
| E | Res 509# | Pennsylvania | Wireless Devices and Cell Tower Health and Safety | RESOLVED, That our American Medical Association oppose legislation that blocks the public's right to guard its own safety and health regarding cell tower placement (New HOD Policy); and be it furtherRESOLVED, That our AMA promote ways to reduce radiation exposure from wireless devices, especially for pregnant women and children (wired devices preferable to wireless, shielding, etc.). (Directive to Take Action) |
| E | Res 510# | MSS | Opposition to Sobriety Requirement for Hepatitis C Treatment | RESOLVED, That our American Medical Association amend Policy H-440.845, “Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment,, by the addition and deletion to read as follows:Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment, H-440.845Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC, Indian Health Service (IHS) and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) advocate, in collaboration with state and specialty medical societies, as well as patient advocacy groups, for the elimination of sobriety requirements, fibrosis restrictions, and prescriber restrictions for coverage of HCV treatment by public and private payors; (5~~4~~) support programs aimed at training providers in the treatment and management of patients infected with HCV; (6~~5~~) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; (7~~6~~) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; (8~~7~~) encourage equitable reimbursement for those providing treatment: (9) encourage the allocation of targeted funding to increase HCV treatment for IHS patients insured by plans subject to HCV treatment restrictions. (Modify Current HOD Policy) |
| F | BOT 18 | n/a | Financial Protections for Doctors in Training | 1. That our American Medical Association (AMA) support the availability of retirement plans for residents and fellows at all teaching institutions that are no less favorable than those offered to other institution employees. (New HOD Policy)
2. That AMA Policy H-310.912, “Residents and Fellows’ Bill of Rights,” be amended by addition and deletion to read as follows:

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians’ Bill of Rights.4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution’s process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or “protected time” for resident and fellow education by “core faculty,” program directors, and assistant/associate program directors.7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.8. ~~7~~ Our AMA adopts the following “Residents and Fellows’ Bill of Rights” as applicable to all resident and fellow physicians in ACGME-accredited training programs:RESIDENT/FELLOW PHYSICIANS’ BILL OF RIGHTSResidents and fellows have a right to: […]E. Adequate compensation and benefits that provide for resident well-being and health.[…](3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided. (Modify Current HOD Policy) |
| F | BOT 19 | n/a | Advocacy for Physicians with Disabilities | 1. That our American Medical Association (AMA) establish an advisory group composed of AMA members who themselves have a disability to work toward inclusion for physicians with disabilities in all AMA activities. (Directive to Take Action)
2. That our AMA promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent. (Directive to Take Action)
3. That our AMA develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians to manage their own disability-related needs in the workplace. (Directive to Take Action)
4. That our AMA communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians with visible and invisible disabilities. (Directive to Take Action)
5. That part 1 of Policy D-90.991, Advocacy for Physicians with Disabilities, be rescinded as having been accomplished by this report. (Modify Current HOD Policy)
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| F | CLRPD 01 | n/a | Minority Affairs Section Five-Year Review | The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Minority Affairs Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action) |
| F | CLRPD 02 | n/a | Integrated Physician Practice Section Five-Year Review | The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Integrated Physician Practice Section through 2026 with the next review no later than the 2026 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action) |
| F | HOD Comp Report | n/a | Report of the House of Delegates Committee on the Compensation of the Officers | RECOMMENDATIONS1. That there be no changes to the Officers’ compensation for the period beginning July 1, 2021 through June 30, 2022. (Directive to Take Action)2. That the travel policy and the Board travel and expense standing rules be amended by addition, shown with underscores as follows:Transportation1. Air: AMA policy on reimbursement for domestic air travel for members of the Board is that the AMA will reimburse for coach fare only. The Presidents (President, Immediate Past President and President Elect) will each have access to an individual $5,000 term allowance (July 1 to June 30) and during the pilot, all other Officers will each have access to $1,250 (pilot extends from November 15, 2021 to April 15, 2022) to use for upgrades as each deems appropriate, typically when traveling on an airline with non-preferred status. The unused portion of the allowance is not subject to carry forward or use by any other Officer and remains the property of the AMA. In rare instances it is recognized that short notice assignments may require up to first class travel because of the lack of availability of coach seating, and this will be authorized when necessary by the Board Chair, prior to travel. Business Class airfare is authorized for foreign travel on AMA business. (Also see Rule IV--Invitations, B—Foreign, for policy on foreign travel). (Directive to Take Action)

3. That the remainder of the report be filed. |
| F | Res 601 | SPS | Virtual Water Cooler for our AMA | RESOLVED, That our American Medical Association explore options facilitating the ability of members to identify and directly contact other members who are interested in participating in informal inter-member mentoring, in order that self-selected members may readily enter into collegial communications with one another; and shall report back such options to the HOD within 12 months. (Directive to Take Action) |
| F | Res 602 | MSS | Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings | RESOLVED, That our American Medical Association amend Policy D-135.997, “Research into the Environmental Contributors to Disease,” by addition and deletion to read as follows: ~~Research into the~~ Environmental Contributors to Disease and Advocating for Environmental Justice D-135.997Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as ~~a~~ priority public health issues; (3) encourage federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies (Modify Current HOD Policy); and be it furtherRESOLVED, That our AMA commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization (Directive to Take Action); and be it furtherRESOLVED, That our AMA create educational programs for and encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization (Directive to Take Action); and be it further RESOLVED, That our AMA report the progress on implementing this resolution at each annual meeting hereafter. (Directive to Take Action) |
| F | Res 603 | MSS | Abolishment of the Resolution Committee | RESOLVED, That our American Medical Association abolish the Resolution Committee by amending the AMA Bylaws B-2.13.3, “Resolution Committee,” as follows by deletion: **~~Resolution Committee. B-2.13.3~~**~~The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.~~~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.~~~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.~~~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~~~2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.~~~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.~~ (Modify Bylaws) |
| F | Res 604 | Texas | The Critical Role of Physicians in the COVID-19 Pandemic | RESOLVED, That our American Medical Association create and fund a public awareness campaign recognizing the vital role physicians have played in the COVID-19 pandemic and highlighting:* Physician leadership in public health messaging, raising awareness of vital prevention and treatment recommendations;
* Medical treatment of patients during this time of great crisis;
* Remembrance of physicians who died of COVID-19 while rendering care during the pandemic;
* The personal sacrifices borne by physicians related to the pandemic; and
* The emotional stress from the long hours spent taking care of patients (Directive to Take Action); and be it further

RESOLVED, That the target audience for this campaign be physicians, legislators, and the public (Directive to Take Action); and be it furtherRESOLVED, That the purpose of this campaign is to thank our physician colleagues and make government officials and the public aware of the personal costs physicians have shouldered during this crisis. (Directive to Take Action) |
| F | Res 605 | Texas | Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates | RESOLVED, That the Bylaws of the American Medical Association be amended to provide that the Resolution Committee be responsible for reviewing resolutions submitted for consideration at all meetings of the American Medical Association House of Delegates and determining compliance of the resolutions with the purpose of any such meeting (Modify Bylaws); and be it further RESOLVED, That the membership of the Resolution Committee reflect the diversity of the House of Delegates (New HOD Policy); and be it further RESOLVED, That the Resolution Committee rules be written to produce impartial results and appropriate changes be made to the AMA Bylaws as necessary to empower the committee. (Modify Bylaws) |
| F | Res 606 | Texas | Increasing the Effectiveness of Online Reference Committee Testimony | RESOLVED, That our American Medical Association conduct a trial of no less than two-years during which all reference committees, prior to the in-person reference committee hearing, produce a preliminary reference committee report based on the written online testimony (Directive to Take Action); and be it further RESOLVED, That the preliminary reference committee document become the agenda for discussion at the in-person reference committee (Directive to Take Action); and be it further RESOLVED, That after the trial period there be an evaluation to determine if this procedure should continue (Directive to Take Action); and be it furtherRESOLVED, That AMA pursue any bylaw changes that might be necessary to allow this trial (Modify Bylaws); and be it further RESOLVED, That the period for online testimony be no longer than 10 days.) (Directive to Take Action) |
| F | Res 607 | American Association of Public Health Physicians | AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels | RESOLVED, That our American Medical Association declare that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe (New HOD Policy); and be it furtherRESOLVED, That our AMA urge all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels (Directive to Take Action); and be it furtherRESOLVED, That our AMA send letters to the nineteen largest health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest (Directive to Take Action); and be it furtherRESOLVED, That our AMA will report the status of AMA’s implementation of our 2018 fossil fuels divestment policies (D-135.969 and H-135.921), and of this resolution, at the 2022 Interim Meeting of the House of Delegates. (Directive to Take Action) |
| F | Res 608 | RFS | Fulfilling Medicine’s Social Contract with Humanity in the Face of the Climate Health Crisis | RESOLVED, That our American Medical Association reaffirm Policy H-135.949, “Support of Clean Air and Reduction in Power Plant Emissions,” (Reaffirm HOD Policy); and be it furtherRESOLVED, That our AMA establish a climate crisis campaign that will distribute evidence-based information on the relationship between climate change and human health, determine high-yield advocacy and leadership opportunities for physicians, and centralize our AMA’s efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050. (Directive to Take Action) |
| F | Res 609 | California | Fulfilling Medicine’s Social Contract with Humanity in the Face of the Climate Health Emergency | RESOLVED, That our American Medical Association declare climate change is an urgent public health emergency that threatens the health and well-being of all individuals (New HOD Policy); and be it furtherRESOLVED, That our AMA support equitable policies to achieve global peaking of greenhouse gas emissions as soon as possible and to achieve a climate neutral world by mid-century in alignment with Paris Agreements (New HOD Policy); and be it furtherRESOLVED, That our AMA, study our existing climate change policies and report back to the House of Delegates at the 2022 Interim Meeting with specific recommendations on how AMA will enact these policies, particularly advocacy priorities, in order to fulfill our commitments as stated in the AMA’s *Declaration of Professional Responsibility (*[*H-140.900)*](https://policysearch.ama-assn.org/policyfinder/detail/medical%20ethic?uri=%2FAMADoc%2FHOD.xml-0-431.xml) in the face of the climate crisis. (Directive to Take Action) |
| F | Res 610 | Florida | Creation of Employed Physician Section | RESOLVED, That our American Medical Association study the necessity and feasibility to create a Section for Employed Physicians (Directive to Take Action); and be it further RESOLVED, That the section would work toward determining problems associated with employment; recommend solutions; and utilize necessary resources when resolving conflicts and challenges between employed physicians and their employers. (Directive to Take Action) |
| F | Res 611\* | New York | September 11th as a National Holiday | RESOLVED, That our American Medical Association support and recognize September 11th as an annual day of observance to remember and recognize all who died and who continue to suffer health consequences from the events of 9/11, to honor first- and all responders from around the country, and to recognize and forever remind us of the unity our country experienced on 9/11/01 and the months that followed. (New HOD Policy) |
| F | Res 612\* | New York | UN International Radionuclide Therapy Day Recognition | RESOLVED, That our American Medical Association support the efforts of the American College of Nuclear Medicine to create and introduce a United Nations General Assembly (UNGA) Resolution for the creation of a new International Day of recognition with the suggested name of “International Radionuclide Therapy Day.” (Directive to Take Action) |
| F | Res 613\* | Mississippi | Due Process at our AMA | RESOLVED, That any American Medical Association member accused of any offense internal to AMA, such as a complaint on/to the AMA Code of Conduct Hotline at 800-398-1496 ([AMA Code of Conduct for meeting attendees and employees | American Medical Association (ama-assn.org)](https://www.ama-assn.org/general-information/general-information/ama-code-conduct-meeting-attendees-and-employees) be entitled to due process based on principles of fundamental fairness before any adverse action may be taken against such AMA member as a result of any such complaint, including but not limited to notice of complaint and opportunity to be heard coincident with any AMA based investigation (New HOD Policy); and be it furtherRESOLVED, That our AMA prohibit inappropriate usage of AMA public or private media platforms and take reasonable steps to enforce the existing Digital Code of Conduct ([Code of Conduct | American Medical Association (ama-assn.org)](https://www.ama-assn.org/general-information/general-information/code-conduct) including but not limited to prompt and thorough investigation of alleged violations of the Digital Code of Conduct as if the complaint were formally filed on the Code of Ethics Hotline. (New HOD Policy) |
| F | Res 614\* | New Jersey | Insurance Industry Behaviors | RESOLVED, That our American Medical Association step up its ongoing review of the proper use of the AMA CPT Code and Vignettes in medical billing claims payments and its misuse by the US Health Insurance Industry (Directive to Take Action); and be it further RESOLVED, That our AMA undertake as soon as practical a formal, legal review of ongoing grievous behaviors of the health insurance industry including: (1) a search for potential litigation partners across the medical federation; and (2) dissemination of the findings to the appropriate internal AMA divisions and Councils for review and preparation for potential civil, regulatory and/or legislative action by/in the US Court System, the US Federal or State regulatory agencies and/or the US Congress. (Directive to Take Action) |
| F | Res 615\* | Oklahoma | Employed Physicians | RESOLVED, That our American Medical Association dedicate full-time staff to the Employed Physician to aggressively address relevant AMA Policy pertaining to the Employed Physician (Directive to Take Action); and be it furtherRESOLVED, That our AMA study amending Policy G-615.105 to read as follows: Employed Physicians and the AMA G-615.1051. Our AMA will become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. 2. As a benefit of membership our AMA will provide assistance, such as information, advice, and legal opinions, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts, contract negotiations and contract renewals, medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.3. Our AMA will also work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. (Directive to Take Action); and be it furtherRESOLVED, That the representation of the Organized Medical Staff Section (OMSS) in the AMA House of Delegates be increased from the current one Delegate to many Delegates based on AMA membership numbers of employed physicians using the mathematical model(s), to calculate the numbers of the New OMSS Delegates, currently being used at AMA for the Medical Student and Resident and Fellows Sections to calculate the numbers of Regional Medical Students and the numbers of Regional Resident/Fellows in the AMA House of Delegates. The AMA would develop a practical meaning of the phrase “Employed Physician” for the purposes of AMA membership counting, but as an editorial comment, the SED suggests starting with employed Non-Resident/Non-Fellow physicians who have no ownership interest (or, say, less than 1% ownership each) in their employer organization (New HOD Policy); and be it further RESOLVED, That the Organized Medical Staff Section have one designated member who is a defined employed physician on all AMA Boards and Committees and Councils to match the MSS, the RFS and the YPS. (New HOD Policy) |
| F | Res 616\* | Michigan | Financial Impact and Fiscal Transparency of the American Medical Association CurrentProcedural Terminology® System | RESOLVED, That our American Medical Association survey physicians about and study the impact of the 2021 CPT® Evaluation and Management coding reform on physicians, among all specialties, in private and employed practices and report the findings and any recommendations at the June 2022 meeting of the House of Delegates. (Directive to Take Action) |
| F | Res 617\* | Louisiana | Together We are Stronger Marketing Campaign | RESOLVED, That our American Medical Association consider readoption of the “Together We are Stronger” tagline as the main marketing slogan and campaign for the organization. (Directive to Take Action) |
| F | Res 618# | RFS | Dissolution of the Resolution Committee | RESOLVED, That our American Medical Association remove the Interim Meeting focus requirement by amending the AMA Bylaws B-2.12.1.1 “Business of Interim Meeting,” as follows by deletion: **~~2.12.1.1 Business of Interim Meeting.~~** ~~The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.~~; and be it furtherRESOLVED, That our AMA dissolve the Resolution Committee by amending the AMA Bylaws B-2.13.3, “Resolution Committee,” as follows by deletion:**~~Resolution Committee. B-2.13.3~~**~~The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.~~~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.~~~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.~~~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~~~2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.~~~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.~~ |
| F | Res 619# | MAS | Continuing Equity Education | RESOLVED, That our American Medical Association establish an Open Forum on Health Equity, to be held annually at a House of Delegates Meeting, for members to directly engage in educational discourse and strengthen organizational capacity to advance and operationalize equity. (Directive to Take Action) |
| G | CMS 02 | n/a | Access to Health Plan Information regarding Lower-Cost Prescription Options | 1. That our American Medical Association (AMA) continue to support efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of all physicians, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient. (New HOD Policy)
2. That our AMA advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an RTPB standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish RTPB tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy)
3. That our AMA develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize RTPB tools and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment. (Directive to Take Action)
4. That our AMA amend Policy H-110.990[3] by addition, as follows:

Our AMA: … 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient’s medical condition. (Modify Current HOD Policy)1. That our AMA amend Policy H-125.974 by addition and deletion as follows:

Our AMA will: . . .(4) will advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors;(5) will advocate to the ONC to include proven and established real-time pharmacy benefit criteria within its certification program;(~~5~~6) will advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTPB) within their products do so without ~~minimal~~ disruption to EHR usability and minimal to no cost to physicians and hospitals; and… (Modify Current HOD Policy)1. That our AMA reaffirm Policy H-450.938 which states that physicians should have easy access to and review the best available data associated with costs at the point of decision-making, which necessitates that cost data be delivered in a reasonable and useable manner by third-party payers and purchasers. The policy also calls for physicians to seek opportunities to improve their information technology infrastructures to include new and innovative technologies to facilitate increased access to needed and useable evidence and information at the point of decision-making. (Reaffirm HOD Policy)
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| G | CMS 04 | n/a | Financing of Home and Community-Based Services | 1. That our American Medical Association (AMA) support federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS). (New HOD Policy)
2. That our AMA support policies that help train, retain, and develop an adequate HCBS workforce (New HOD Policy)
3. That our AMA support efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS. (New HOD Policy)
4. That our AMA support that Medicaid’s Money Follows the Person demonstration program be extended or made permanent. (New HOD Policy)
5. That our AMA support cross-agency and federal-state strategies that can help improve coordination] among HCBS programs and streamline funding and the provision of services. (New HOD Policy)
6. That our AMA support HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices. (New HOD Policy)
7. That our AMA support that the Centers for Medicare & Medicaid Services and private insurers offer flexibility to implement hospital at home programs for the subset of patients who meet the criteria used by hospital at home programs. (New HOD Policy)
8. That our AMA reaffirm Policy H-280.945, which provides a comprehensive set of principles to improve the financing of long-term services and supports and supports incentivizing states to expand the availability of and access to HCBS and permitting Medigap and Medicare Advantage plans to offer a respite care benefit. (Reaffirm HOD Policy)
9. That our AMA reaffirm Policy H-290.958 which supports increases in states’ Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. (Reaffirm HOD Policy)
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| G | CMS/CSAPH Joint Report | n/a | Reducing Inequities and Improving Access to Insurance for Maternal Health Care | 1. That our American Medical Association (AMA) acknowledge that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color. (New HOD Policy)
2. That our AMA encourage physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust. (New HOD Policy)
3. That our AMA encourage physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourage physician leaders of health care teams to support similar appropriate professional education for all members of their teams. (New HOD Policy)
4. That our AMA continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers. (New HOD Policy)
5. That our AMA promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:

(a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories), (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and (c) lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes. (Directive to Take Action)1. That our AMA support the development of a standardized definition of maternal mortality and the allocation of resources to states to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity. (New HOD Policy)
2. That our AMA encourage hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families. (New HOD Policy)
3. That our AMA encourage the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient. (New HOD Policy)
4. That our AMA support adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care. (New HOD Policy)
5. That our AMA amend Policy D-290.974 by addition and deletion as follows:

Our AMA will work with relevant stakeholders to support, at the state and federal levels, extension of Medicaid and State Children’s Health Insurance Program (CHIP) coverage to at least 12 months after the end of pregnancy ~~postpartum~~. (Modify Current HOD Policy)1. That our AMA reaffirm Policy H-350.974, which highlights the elimination of racial and ethnic disparities in health care as an issue of highest priority for the AMA; encourages physicians to examine how their own practices help increase the awareness within the profession of racial disparities in medical treatment decisions; supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; and supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy D-420.993, which states that the AMA will work with the Centers for Disease Control and Prevention, United States (US) Department of Health and Human Services, state and county health departments to decrease maternal mortality rates in the US; encourage and promote all state and county health departments to develop a maternal mortality surveillance system; and work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy D-290.979, which supports collaborative efforts with state and specialty medical societies to advocate at the state level for expanded Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm AMA Policy)
4. That our AMA reaffirm Policy H-165.855, which supports 12-month continuous eligibility across Medicaid, Children’s Health Insurance Program, and exchange plans to limit patient churn and promote continuity and coordination of care; and also supports development of a mechanism to allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (Reaffirm HOD Policy)
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| G | Res 701 | MSS | Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients Ineligible for Medicaid | RESOLVED, That our American Medical Association amend Policy H-290.974, “Extending Medicaid Coverage for One Year Postpartum,” by addition as follows to read as follows:Extending Medicaid Coverage for One Year Postpartum D-290.9741) Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum~~.~~; and2) Our AMA will work with relevant stakeholders to expand Medicaid eligibility for pregnant and postpartum non-citizen immigrants. (Modify Current HOD Policy); and be it further RESOLVED, That our AMA amend Policy H-165.828, “Health Insurance Affordability,” by addition as follows:H-165.828 – HEALTH INSURANCE AFFORDABILITY1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage.3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. (Modify Current HOD Policy) |
| G | Res 702 | Ohio | System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access | RESOLVED, That our American Medical Association encourage and advocate health care insurers and Medicare/Medicaid Products to ensure that the systems of communication for prior authorization include: live personnel access, simplification of website navigation, immediate response with confirmation number of submission and an expedient decision for authorizations. (Directive to Take Action) |
| G | Res 703 | American Academy of Pediatrics | Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes | RESOLVED, That our American Medical Association identify and collect data regarding payer deviation from CPT code descriptors to adjudicate claims, assess efficacy of and challenges in existing appeals and hassle factor processes available to physicians, and prepare and present a report at the 2022 House of Delegates Interim Meeting. (Directive to Take Action) |
| G | Res 704 | RFS | Expanding the AMA’s Study on the Economic Impact of COVID-19 | RESOLVED, That our American Medical Association work with relevant organizations and stakeholders to study the economic impact and long-term recovery of the COVID-19 pandemic on healthcare institutions in order to identify and better understand which groups of physicians, patients and organizations may have been disproportionately affected by the financial burdens of the COVID-19 pandemic (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with relevant organizations and stakeholders to study the overall economic impact of office closures, cancellations of elective surgeries and interruptions in patient care, as well as the economic impact of utilizing telemedicine for an increasing percentage of patient care. (Directive to Take Action) |
| G | Res 705 | Texas | Advocating for Program Stability in the Merit-Based Incentive Payment System | RESOLVED, That our American Medical Association call on the Centers for Medicare & Medicaid Services to implement an automatic hardship exception for participants in the Merit‑Based Incentive Payment System for the 2021 performance year due to the COVID-19 public health emergency. (Directive to Take Action) |
| G | Res 706 | Texas | Support for State Medical Record Retention Laws | RESOLVED, That our American Medical Association advocate that the Centers for Medicare & Medicaid Services do not supersede state medical record retention laws in the U.S. (Directive to Take Action) |
| G | Res 707\* | New York | Fifteen Month Lab Standing Orders | RESOLVED, That our American Medical Association advocate the Centers for Medicare and Medicaid Services to allow standing laboratory orders to be active for fifteen (15) months. (Directive to Take Action) |
| G | Res 708\* | New York | Insurance Coverage for Scalp Cooling (Cold Cap) Therapy | RESOLVED, That our American Medical Association advocate for and seek through legislation and/or regulation, universal insurance coverage for Scalp Cooling (Cold Cap) Therapy (Directive to Take Action); and be it furtherRESOLVED, That our AMA work with consumer and advocacy groups to challenge insurers on medical necessity denials for Scalp Cooling (Cold Cap) Therapy and encourage appeals to independent third-party reviewers. (Directive to Take Action) |
| G | Res 709\* | New York | Prior Authorization – CPT Codes for Fair Compensation | RESOLVED, That our American Medical Association include in any model legislation and as a basis for all advocacy, fair compensation based on CPT codes for appeal of wrongfully denied services, including those for prior authorization reforms and that CPT codes must fully reflect the aggregated time and effort expended by physician practices (Directive to Take Action); and be it furtherRESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT® Editorial Panel to account for administrative work involved in prior authorizations that reflects the actual time expended by physician practices to advocate on behalf of patients and to comply with insurer requirements (Directive to Take Action); and be it furtherRESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT® Editorial Panel to account for administrative work that reflects the actual time expended by physician practices and their billing vendors involved in successfully appealing wrongful pre-and post-service denials. (Directive to Take Action) |
| G | Res 710\* | New York | Physician Burnout is an OSHA Issue | RESOLVED, That our American Medical Association seek legislation/regulation to add physician burnout as a Repetitive Strain (Stress) Injury and subject to Occupational Safety and Health Administration (OSHA) oversight. (Directive to Take Action) |
| G | Res 711# | PPPS | Health System Consolidation | RESOLVED, That our American Medical Association undertake an annual report assessing nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation. (Directive to Take Action) |
| G | Res 712# | PPPS | Advocacy of Private Practice Options for Healthcare Operations in Large Corporations | RESOLVED, That our American Medical Association study the best method to create pilot programs which advance the advocacy of private practice and small business medicine within the rapidly growing area of internal healthcare within Fortune 500 corporations in American with a report back at the 2022 Annual Meeting (Directive to Take Action); and be it furtherRESOLVED, That our AMA prioritize advocacy efforts that emphasize small private practice utilization within the investment and business efforts that Fortune 500 corporations are currently undertaking into the healthcare industry. (Directive to Take Action) |

\* Contained in the Handbook Addendum

# Contained in the Friday Tote

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