APPENDIX 1 - REPORTS OF REFERENCE COMMITTEES
2024 Annual Meeting of the American Medical Association House of Delegates

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

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

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

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

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

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-24)

Report of Reference Committee on Amendments to Constitution and Bylaws

Emily Briggs, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT Report 02- New Specialty Organizations Representation in the House of Delegates
2. BOT Report 36 - Specialty Society Representation in the House of Delegates - Five-Year Review
3. CCB Report 01 - AMA Bylaws—Nomination of Officers and Council Members
4. CCB Report 04 - AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.)
5. CEJA Report 01 - Short-Term Global Health Clinical Encounters
6. CEJA Report 02 - Research Handling of De-Identified Patient Data (D-315.969)
7. CEJA Report 04 - Physicians' Use of Social Media for Product Promotion and Compensation
8. CEJA Report 05 - CEJA's Sunset Review of 2014 House Policies
9. Resolution 008 - Consolidated Health Care Market
10. Resolution 009 - Updating Language Regarding Families and Pregnant Persons
11. Resolution 013 - Ethical Impetus for Research in Pregnant and Lactating Individuals
12. Resolution 014 - The Preservation of the Primary Care Relationship
13. Resolution 018 - Opposing Violence, Terrorism, Discrimination, and Hate Speech
14. Resolution 020 - Voter Protections During and After Incarceration
15. Resolution 021 - Opposition to Capital Punishment
16. Resolution 024 - Augmented Intelligence and Organized Medical Staff
17. Resolution 025 - The HRSA – Organ Procurement and Transplantation Network (OPTN) Modernization Initiative

RECOMMENDED FOR ADOPTION AS AMENDED

18. CCB Report 02 - AMA Bylaws—Run-Off and Tie Ballots
19. CCB Report 03 - AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section Governing Council Members (D-610.997)
20. Resolution 001 - Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
21. Resolution 003 - Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity
22. Resolution 012 - Ethical Pricing Procedures that Protect Insured Patients

23. Resolution 015 - Health and Racial Equity in Medical Education to Combat Workforce Disparities
24. Resolution 017 - Addressing the Historical Injustices of Anatomical Specimen Use
25. Resolution 019 - Supporting the Health of Our Democracy

RECOMMENDED FOR REFERRAL

26. CEJA Report 03 - Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
27. Resolution 016 - Guiding Principles for the Healthcare of Migrants

RECOMMENDED FOR NOT ADOPTION

28. Resolution 002 - Removal of the Interim Meeting Resolution Committee
29. Resolution 004 - The Rights of Newborns that Survive Abortion
30. Resolution 005 - AMA Executive Vice President
31. Resolution 006 - Treatment of Family Members
32. Resolution 023 - Change Healthcare Security Lapse—The FBI Must Investigate

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

33. Resolution 007 - AMA Supports a Strategy for Eliminating Nuclear Weapons

Amendments
If you wish to propose an amendment to an item of business, click here: SUBMIT NEW AMENDMENT

RECOMMENDED FOR ADOPTION

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

RECOMMENDATION:

Recommendations in Board of Trustees Report 02 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustee Report 02 adopted and the remainder of the Report filed.

Therefore, the Board of Trustees recommend that the Academy of Consultation-Liaison Psychiatry, American College of Lifestyle Medicine, American Venous Forum, Association of Academic Physiatrists, and Society for Pediatric Dermatology be granted representation in the AMA House of Delegates and that the remainder of the report be filed. (Directive to Take Action)

No testimony was heard. Limited online testimony was in unanimous support. Your Reference Committee recommends that BOT Report 02 be adopted.

(2) BOARD OF TRUSTEES REPORT 36 – SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES – FIVE-YEAR REVIEW

RECOMMENDATION

Recommendations for Board of Trustees 36 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 36 adopted and the remainder of the report filed.

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

1. The American Academy of Cosmetic Surgery, American Association for Thoracic Surgery, American Association of Gynecologic Laparoscopists, American Association of Public Health Physicians, American College of Allergy, Asthma and Immunology, American College of Medical Quality, American Society for Reconstructive Microsurgery, American Society of Interventional Pain Physicians, Association of Academic Radiology, GLMA— Health Professionals Advancing LGBTQ+ Equality,

Infectious Diseases Society of America, and Society of Laparoscopic and Robotic Surgeons retain representation in the AMA HOD. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the American Association of Plastic Surgeons, American Society for Metabolic and Bariatric Surgery and American Society of Cytopathology be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)

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

No testimony was heard. There was no online testimony. Your Reference Committee recommends that Board of Trustees Report 36 be adopted.

(3) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 01 - NOMINATION OF OFFICERS AND COUNCIL MEMBERS

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 01 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 01 adopted and the remainder of the report filed.

The Council on Constitution and Bylaws recommends that the following amendments to our AMA Bylaws be adopted, that Policy G-610.989 be rescinded, 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 Officers

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3.3 Nominations. Nominations for President-Elect, Speaker and Vice Speaker, shall be made by a member of the House of Delegates at the opening session of the meeting at which elections take place. Nominations for all other officers, except for Secretary, the medical student trustee, and the public trustee, shall be made by a member of the House of Delegates at the opening session of the meeting at which elections take place.

6 Councils

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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 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. The Chair of the Board of Trustees will present announced candidates, who shall be entered into nomination by the Speaker at the Opening session of the meeting at which elections take place. Nominations may also be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place.

(Modify Bylaws)

No testimony was heard. There was also no online testimony. Your Reference Committee recommends that CCB Report 01 be adopted.

(4) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 04 – AMA BYLAW AMENDMENTS PURSUANT TO AIPSC (2ND ED.)

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report be <u>adopted</u> and the remainder of the report be <u>filed.</u>

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report <u>adopted</u> and the remainder of the report <u>filed.</u>

The Council on Constitution and Bylaws recommends that the following recommendations 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:

1) That our AMA Bylaws be amended by insertion and deletion as follows:

2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on request of one third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall notify each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.

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2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.

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5.2.4 Notice of Meeting. Notice is given if delivered in person, by telephone, or any means of electronic communication approved by the Board of Trustees. Notice shall be deemed to be received upon delivery to the Trustee's contact information then appearing on the records of the AMA.

5.2.4.1 Waiver of Notice. Attendance at any meeting shall constitute a waiver of notice of such meeting, except where such attendance is for the express purpose of objecting to the transacting of any business because of a question as to the legality of the calling or convening of the meeting.

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12.3 Articles of Incorporation. The Articles of Incorporation of the AMA may be amended at any regular or special meeting of the House of Delegates by the approval of two-thirds of the voting members of the House of Delegates registered at the meeting, provided that the Board of Trustees shall have approved the amendment and provided it to each member of the House of Delegates at least 5 days, but not more than 60 days, prior to the meeting of the House of Delegates at which the amendment is to be considered.

(Modify Bylaws)

No testimony was heard. There was also no online testimony. Your Reference Committee recommends that CCB Report 04 be adopted.

(5) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 01 - SHORT-TERM GLOBAL HEALTH CLINICAL ENCOUNTERS

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 01 be <u>adopted</u> and the remainder of the Report be <u>filed.</u>

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 01 <u>adopted</u> and the remainder of the Report <u>filed.</u>

In light of these considerations, the Council on Ethical and Judicial Affairs recommends that the following be adopted, and the remainder of this report be filed:

Short-term global health clinical encounters, which send physicians and physicians in training from wealthier communities to provide care in under-resourced settings for a period of days or weeks, have been promoted as a strategy to provide needed care to individual patients and, increasingly, as a means to address global health inequities. To the extent that such encounters also provide training and educational opportunities, they may offer benefit both to the host communities and the medical professionals and trainees who volunteer their time and clinical skills.

Short-term global health clinical encounters typically take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities for participants, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate resources. Participants and sponsors must focus not only on enabling good health outcomes for individual patients, but on promoting justice and sustainability, minimizing burdens on host communities, and respecting persons and local cultures. Responsibly carrying out short-term global health clinical encounters requires diligent preparation on the part of participants and sponsors in collaboration with host communities.

Physicians and trainees who are involved with short-term global health clinical encounters 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 project parameters, including identifying community needs, project goals, and how the visiting medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term global health clinical encounters should prioritize efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the visiting medical team or the sponsoring organization.

(b) Seek to proactively identify and minimize burdens the trip places on the host community, including not only direct, material costs of hosting participants, but also possible adverse effects the presence of participants could have for beneficial local practices and local practitioners. Sponsors and participants should ensure that team members practice only within their skill sets and experience.

(c) Provide resources that help them become broadly knowledgeable about the communities in which they will work and 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 visiting medical team are expected to uphold the ethics standards of their profession and participants should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, participants may withdraw from care of an individual patient or from the project after careful consideration of the effect that will have on the patient, the medical team, and the project overall, in keeping with ethics guidance on the exercise of conscience. Participants should be clear that they may be ethically required to decline requests for treatment that cannot be provided safely and effectively due to resource constraints.

(d) Are organized by sponsors that embrace a mission to promote justice, patient-centered care, community welfare, and professional integrity. Physicians, as influential members of their health care systems, are well positioned to influence the selection, planning and preparation for short term encounters in global health. In addition, they can

take key roles in mentoring learners and others on teams to be deployed. Physicians can also offer guidance regarding the evaluation process of the experience, in an effort to enhance and improve the outcomes of future encounters.

Sponsors of short-term global health clinical encounters should:

(e) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally. This includes arranging for local mentors, translation services, and participants' personal health needs. It should not be assumed that host communities can absorb additional costs, even on a temporary basis.

(f) Proactively define appropriate roles and permissible range of practice for members of the visiting medical team, so that they can provide safe, high-quality care in the host community. Team members should practice only within the limits of their training and skills in keeping with professional standards they would deem acceptable in their ordinary clinical practice, even if the host community's standards are more flexible or less rigorously enforced.

(g) Ensure appropriate supervision of trainees, consistent with their training in their home communities, and make certain that they are only permitted to practice independently in ways commensurate with their level of experience in under-resourced settings.

(h) Ensure a mechanism for meaningful data collection is in place, consistent with recognized standards for the conduct of health services research and quality improvement activities in the sponsor's country.

(New HOD/CEJA Policy)

Testimony was heard in unanimous support and appreciation of CEJA's multiple iterations of the report. There was no online testimony. Your Reference Committee recommends that CEJA Report 01 be adopted.

(6) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 02 - RESEARCH HANDLING OF DE-IDENTIFIED PATIENT DATA (D-315.969)

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 02 be <u>adopted</u>.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 02 <u>adopted</u>.

In light of the challenges considered with regard to constructing a framework for holding stakeholders accountable within digital health information ecosystems, the Council on Ethical and Judicial Affairs recommends:

1. That the following be adopted:

Within health care systems, identifiable private health information, initially derived from and used in the care and treatment of individual patients, has led to the creation of massive de-identified datasets. As aggregate datasets, clinical data takes on a secondary promising use as a means for quality improvement and innovation that can be used for the benefit of future patients and patient populations. While de-identification of data is meant to protect the privacy of patients, there remains a risk of re-identification, so while patient anonymity can be safeguarded it cannot be guaranteed. In handling patient data, individual physicians thus strive to balance supporting and respecting patient privacy while also upholding ethical obligations to the betterment of public health.

When clinical data are de-identified and aggregated, their potential use for societal benefits through research and development is an emergent, secondary use of electronic health records that goes beyond individual benefit. Such data, due to their potential to benefit public health, should thus be treated as a form of public good, and the ethical standards and values of health care should follow the data and be upheld and maintained even if the data are sold to entities outside of health care. The medical profession's responsibility to protect patient privacy as well as to society to improve future health care should be recognized as inherently tied to these datasets, such that all entities granted access to the data become data stewards with a duty to uphold the ethical values of health care in which the data were produced.

As individuals or members of health care institutions, physicians should:

(a) Follow existing and emerging regulatory safety measures to protect patient privacy;
(b) Practice good data intake, including collecting patient data equitably to reduce bias in datasets;
(c) Answer any patient questions about data use in an honest and transparent manner to the best of their ability in accordance with current federal and state legal standards.

Health care entities, in interacting with patients, should adopt policies and practices that provide patients with transparent information regarding:

(d) The high value that health care institutions place on protecting patient data;
(e) The reality that no data can be guaranteed to be permanently anonymized, and that risk of re-identification does exist;
(f) How patient data may be used;
(g) The importance of de-identified aggregated data for improving the care of future patients.

Health care entities managing de-identified datasets, as health data stewards, should:
(h) Ensure appropriate data collection methods and practices that meet industry standards to support the creation of high-quality datasets;
(i) Ensure proper oversight of patient data is in place, including Data Use/Data Sharing Agreements for the use of de-identified datasets that may be shared, sold, or resold;
(j) Develop models for the ethical use of de-identified datasets when such provisions do not exist, such as establishing and contractually requiring independent data ethics

review boards free of conflicts of interest and verifiable data audits, to evaluate the use, sale, and potential resale of clinically-derived datasets;

(k) Take appropriate cyber security measures to seek to ensure the highest level of protection is provided to patients and patient data;

(l) Develop proactive post-compromise planning strategies for use in the event of a data breach to minimize additional harm to patients;

(m) Advocate that health- and non-health entities using any health data adopt the strongest protections and seek to uphold the ethical values of the medical profession.

There is an inherent tension between the potential benefits and burdens of de-identified datasets as both sources for quality improvement to care as well as risks to patient privacy. Re-identification of data may be permissible, or even obligatory, in rare circumstances when done in the interest of the health of individual patients. Re-identification of aggregated patient data for other purposes without obtaining patients' express consent, by anyone outside or inside of health care, is impermissible. (New HOD/CEJA Policy); and

2. That Opinion 2.1.1, "Informed Consent"; Opinion 3.1.1, "Privacy in Health Care"; Opinion 3.2.4, "Access to Medical Records by Data Collection Companies"; and Opinion 3.3.2, "Confidentiality and Electronic Medical Records" be amended by addition as follows:

a. Opinion 2.1.1, Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. Transparency with patients regarding all medically appropriate options of treatment is critical to fostering trust and should extend to any discussions regarding who has access to patients' health data and how data may be used.

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

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

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

(i) the diagnosis (when known);

(ii) the nature and purpose of recommended interventions;

(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to

participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines. (Modify HOD/CEJA Policy)

b. Opinion 3.1.1, Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.
Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest

extent possible and should:
(a) Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.
(b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
(c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.
(d) Be transparent with any inquiry about existing privacy safeguards for patient data but acknowledge that anonymity cannot be guaranteed and that breaches can occur notwithstanding best data safety practices. (Modify HOD/CEJA Policy)

c. Opinion 3.2.4, Access to Medical Records by Data Collection Companies

Information contained in patients' medical records about physicians' prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment recommendations, such as pharmaceutical or medical device companies.

Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.

Physicians who propose to permit third-party access to specific patient information for commercial purposes should:
(a) Only provide data that has been de-identified.
(b) Fully inform each patient whose record would be involved (or the patient's authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.

Physicians who propose to permit third parties to access the patient's full medical record should:
(c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's medical record.
(d) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.
(e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.

Because de-identified datasets are derived from patient data as a secondary source of data for the public good, health care professionals and/or institutions who propose to permit third-party access to such information have a responsibility to establish that any use of data derived from health care adhere to the ethical standards of the medical profession. (Modify HOD/CEJA Policy)

d. Opinion 3.3.2, Confidentiality and Electronic Medical Records

Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.

Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:

(a) Choose a system that conforms to acceptable industry practices and standards with respect to:
(i) restriction of data entry and access to authorized personnel;
(ii) capacity to routinely monitor/audit access to records;
(iii) measures to ensure data security and integrity; and
(iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.
(b) Describe how the confidentiality and integrity of information is protected if the patient requests.
(c) Release patient information only in keeping with ethics guidance for confidentiality and privacy. (Modify HOD/CEJA Policy); and

3. That the remainder of this report be filed.

Testimony was heard in unanimous support and appreciation of CEJA's multiple iterations of the report. Online testimony was also in unanimous support. Your Reference Committee recommends that CEJA Report 02 be adopted.

(7) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 04 - PHYSICIANS' USE OF SOCIAL MEDIA
FOR PRODUCT PROMOTION AND COMPENSATION

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 04 be adopted.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 04 adopted.

In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends that: Opinion 2.3.2, "Professionalism in the Use of Social Media" be amended by substitution to read as follows and the remainder of this report be filed:

Social media—internet-enabled communication platforms—enable individual medical students and physicians to have both a personal and a professional presence online. Social media can foster collegiality and camaraderie within the profession as well as provide opportunities to widely disseminate public health messages and other health communications. However, use of social media by medical professionals can also undermine trust and damage the integrity of patient-physician relationships and the profession as a whole, especially when medical students and physicians use their social media presence to promote personal interests.

Physicians and medical students should be aware that they cannot realistically separate their personal and professional personas entirely online and should curate their social media presence accordingly. Physicians and medical students therefore should:

(a) When publishing any content, consider that even personal social media posts have the potential to damage their professional reputation or even impugn the integrity of the profession.

(b) Respect professional standards of patient privacy and confidentiality and refrain from publishing patient information online without appropriate consent.

(c) Maintain appropriate boundaries of the patient-physician relationship in accordance with ethics guidance if they interact with their patients through social media, just as they would in any other context.

(d) Use privacy settings to safeguard personal information and content, but be aware that once on the Internet, content is likely there permanently. They should routinely monitor their social media presence to ensure that their personal and professional information and content published about them by others is accurate and appropriate.

(e) Publicly disclose any financial interests related to their social media content, including, but not limited to, paid partnerships and corporate sponsorships.

(f) When using social media platforms to disseminate medical health care information, ensure that such information is useful and accurate based on professional medical judgment.

(Modify HOD/CEJA Policy)

Testimony was mixed but was in general support for referral. Testimony cited the need to more directly address the original resolution and to provide more clarity with respect to item (f) in the report. However, the use of "professional medical judgement" is consistent language throughout the *Code*. Limited online testimony was in support. However, the current report is dramatically different from the previous version seen at the 2023 interim meeting because the report has now been decoupled from the *Code* opinion on the sale of goods in physicians' offices. The current version of the report now only focuses on social media and no longer on the sale of goods. Your Reference Committee recommends that CEJA Report 04 be adopted.

(8) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 05 - CEJA'S SUNSET REVIEW OF 2014 HOUSE POLICIES

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 05 be adopted.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 05 adopted.

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

No testimony was heard. There was also no online testimony. Your Reference Committee recommends that CEJA Report 05 be adopted.

(9) RESOLUTION 008 - CONSOLIDATED HEALTH CARE MARKET

RECOMMENDATION:

Resolution 008 be adopted.

HOD ACTION: Resolution 008 adopted.

1. Our American Medical Association will investigate the possibility of filing a class action lawsuit against Optum, United Health Group and Change Health to recoup the damages from the disruption caused by the breach, and to distribute the unfair enrichment profits made by Optum et al to the practices whose retained payments allowed them to generate interest and investment profits.

2. Our AMA will investigate the acquisition of practices by Optum in the aftermath of the breach and determine if the independence of those practices can be resurrected, and if not, if damages are due to the physician owners of the acquired practices.

Testimony was heard in unanimous support. Online testimony was in general support. Your Reference Committee recommends that Resolution 008 be adopted.

(10) RESOLUTION 009 - UPDATING LANGUAGE REGARDING FAMILIES AND PREGNANT PERSONS

RECOMMENDATION:

Resolution 009 be adopted.

HOD ACTION: Resolution 009 adopted.

Our American Medical Association will review and update the language used in AMA policy and other resources and communications to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures.

Testimony was heard in unanimous support. Online testimony was also in unanimous support. Your Reference Committee recommends that Resolution 009 be adopted.

(11) RESOLUTION 013 - ETHICAL IMPETUS FOR RESEARCH IN PREGNANT AND LACTATING INDIVIDUALS

RECOMMENDATION:

Resolution 013 be adopted.

HOD ACTION: Resolution 013 adopted.

Our American Medical Association Council on Ethical and Judicial Affairs will consider updating its ethical guidance on research in pregnant and lactating individuals.

Testimony was heard in unanimous support. Online testimony was also in unanimous support. Your Reference Committee recommends that Resolution 013 be adopted.

(12) RESOLUTION 014 - THE PRESERVATION OF THE PRIMARY CARE RELATIONSHIP

RECOMMENDATION:

Resolution 014 be adopted.

HOD ACTION: Resolution 014 adopted.

Our American Medical Association opposes health systems requiring patients to switch to primary care physicians within a health system in order to access specialty care.

Our AMA requests the Council on Ethical and Judicial Affairs review the ethical implications of health systems requiring patients to change to primary care clinicians employed by their system to access specialists.

Our AMA advocates for policies that promote patient choice, ensure continuity of care, and uphold the sanctity of the patient-physician relationship, irrespective of healthcare system pressures or economic incentives.

Testimony was heard in unanimous support. One delegation rescinded its online testimony, with the result that the limited online testimony is now in general support. Your Reference Committee recommends that Resolution 014 be adopted.

(13) RESOLUTION 018 - OPPOSING VIOLENCE, TERRORISM, DISCRIMINATION, AND HATE SPEECH

RECOMMENDATION:

That Resolution 018 be <u>adopted.</u>

HOD ACTION: Resolution 018 <u>adopted.</u>

1. Our American Medical Association strongly condemns all acts of violence, terrorism, discrimination, and hate speech against any group or individual, regardless of race, ethnicity, religious affiliation, cultural affiliation, gender, sexual orientation, disability, or other factor.
2. Our AMA affirms its commitment to promoting dialogue, empathy, and mutual respect among diverse communities, recognizing the importance of fostering understanding and reconciliation.
3. Our AMA recognizes the importance of commemorating and honoring the victims of tragedies throughout human history, in a manner that respects the dignity and sensitivities of all affected communities.
4. Our AMA encourages initiatives that promote education, awareness, and solidarity to prevent future acts of violence and promote social cohesion.
5. Our AMA acknowledges the diverse perspectives and experiences within its membership and commits to facilitating constructive dialogue and engagement on sensitive and polarizing issues.
6. Our AMA calls for continued collaboration and partnership with organizations representing diverse communities.

Testimony was limited but in unanimous support. This resolution was brought forward after robust conversation and deliberation, including multiple iterations at the author's delegation level. It captures the sentiments of physicians concerned with the increase in negative, derogatory, and divisive language, behaviors, and actions. Online testimony was also limited. Your Reference Committee recommends that Resolution 018 be adopted.

(14) RESOLUTION 020 – VOTER PROTECTIONS DURING AND AFTER INCARCERATION

RECOMMENDATION:

That Resolution 020 be <u>adopted.</u>

HOD ACTION: Resolution 020 <u>adopted.</u>

Our American Medical Association supports the continuation and restoration of voting rights for citizens currently or formerly incarcerated, support efforts ensuring their ability to exercise their vote during and after incarceration, and oppose efforts to restrict their voting rights.

Our AMA will research the impact of disproportionate policing in and incarceration of minoritized communities on voter participation and health outcomes.

Our AMA will develop educational materials and programming to educate medical trainees and physicians on the impact of incarceration on voting and health outcomes. (Directive to Take Action)

Testimony was heard in strong support. Online Testimony is in general support. In accordance with H-440.805, “Support for Safe and Equitable Access to Voting”, your Reference Committee recognizes that voting is a social determinant of health. Your Reference Committee recommends that Resolution 020 be adopted.

(15) RESOLUTION 021 - OPPOSITION TO CAPITAL PUNISHMENT

RECOMMENDATION:

That Resolution 021 be <u>adopted.</u>

HOD ACTION: Resolution 021 <u>adopted.</u>

RESOLVED, that our American Medical Association amend H-140.896, “Moratorium on Capital Punishment,” by addition and deletion as follows:

<u>Opposition to</u> ~~Moratorium on~~ Capital Punishment H-140.896
Our AMA: (1) opposes all forms of capital punishment; and (2) urges appropriate legislative and legal authorities to continue to implement changes in the system of administration of capital punishment, if used at all, and to promote its fair and impartial administration in accordance with basic requirements of due process. (Modify Current HOD Policy)

Mixed testimony was heard. Testimony in favor supported the AMA adopting a stronger stance clearly opposing capital punishment. Testimony in opposition strongly favored maintaining neutrality. Online testimony is mixed, with opposition citing the subject matter as outside the purview of the AMA. Although overall testimony was mixed, testimony in support came from sections and delegations, whereas testimony in opposition came from individuals. As the AMA *Code of Medical Ethics* currently states "a physician must not participate in a legally authorized execution." This resolution brings AMA policy into alignment with our *Code of Medical Ethics*. Your Reference Committee recommends that Resolution 021 be adopted.

(16) RESOLUTION 024 - AUGMENTED INTELLIGENCE AND ORGANIZED MEDICAL STAFF

RECOMMENDATION:

Resolution 024 be <u>adopted.</u>

HOD ACTION: Resolution 024 <u>adopted.</u>

Resolved, that our American Medical Association modify policy H-225.957, "Principles for Strengthening the Physician-Hospital Relationship," by addition:

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, <u>protection from interruption of delivery of care</u>, and working continuously to improve patient care and <u>health</u> outcomes—<u>including but not limited to the development, selection, and implementation of augmented intelligence</u>—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
(Modify Current HOD Policy);

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

Limited but unanimous testimony was heard in support. No online testimony is presented. Your Reference Committee recommends that Resolution 024 be adopted.

(17) RESOLUTION 025 - THE HRSA – ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK (OPTN) MODERNIZATION INITIATIVE

RECOMMENDATION:

That Resolution 025 be adopted.

HOD ACTION: Resolution 025 adopted.

1. Our American Medical Association affirms that the Health and Resources and Services Administration's (HRSA) proposed changes to the Organ Procurement and Transplantation Network (OPTN) should not replace the existing public-private partnership between HRSA and the OPTN, and the OPTN should be maintained as a membership organization.

2. Our AMA supports an Organ Procurement and Transplantation Network (OPTN) Board, per the National Organ Transplant Act (NOTA) regulations, that includes patients, living donors and donor families, transplant centers, organ procurement organizations (OPOs), patient and medical associations, and other transplant stakeholders to ensure experience, expertise, and knowledge from content experts; and should be elected by the membership rather than be appointed or elected by the government or its contractors which would result in politicizing medical care decisions.

3. Our AMA proactively advocates to the general public and encourage legislators and regulators to modernize the transplant system in a transparent, equitable, and efficient manner within the structure outlined in National Organ Transplant Act (NOTA).

Testimony was heard in unanimous support. There is no online testimony. Your Reference Committee recommends that Resolution 025 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(18) COUNCIL ON CONSTITUTION AND BYLAWS REPORT
02 - RUN-OFF AND TIE BALLOTS

RECOMMENDATION A:

That part 3.4.1.2 of Council on Constitution and Bylaws Report 02 be amended by addition and deletion:

3.4.2.1.2 ~~3~~ Subsequent Ballots. If all vacancies for Trustees are not filled on the first ballot, and there are more than two remaining nominees, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, ~~both~~ all tied nominees shall be dropped. If these actions would result in fewer than two nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. On any subsequent ballot, a nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the larger number of votes within the number of Trustees to be elected or remaining to be elected. ~~and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees.~~ This procedure shall be repeated until all vacancies have been filled.

RECOMMENDATION B:

That part 3.4.2.2 of the Council on Constitution and Bylaws Report 02 be amended by addition and deletion:

3.4.2.2 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, ~~both~~ all tied nominees shall be dropped. If these actions would result in fewer than two nominees, the nominee(s) with the fewest

votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. ~~**the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie.**~~ **This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.**

RECOMMENDATION C:

That the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Constitution and Bylaws Report 02 adopted as amended with the remainder of the report filed.

The Council on Constitution and Bylaws recommends that the following amendments to our 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 Officers

***

3.4 Elections.

***

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.

3.4.2.1 At-Large Trustees.

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

~~**3.4.2.1.2 Runoff Ballot**. A runoff election shall be held to fill any vacancy not filled because of a tie vote.~~

3.4.2.1.2 ~~**3**~~ **Subsequent Ballots.** If all vacancies for Trustees are not filled on the first ballot, and there are more than two remaining nominees, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two nominees, the nominee(s) with the fewest votes

shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. On any subsequent ballot, a nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the larger number of votes within the number of Trustees to be elected or remaining to be elected. ~~and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees.~~ This procedure shall be repeated until all vacancies have been filled.

3.4.2.2 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. ~~the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie.~~ This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

***

6 Councils

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

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6.8.1.1 Separate Election. The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions result in fewer than two nominees, the nominees with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. ~~nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and~~

~~eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie.~~ This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

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

~~**6.8.1.3 Run-Off Ballot.** A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.~~

~~**6.8.1.4**~~ **Subsequent Ballots.** If all vacancies are not filled on the first ballot, and there are more than two remaining nominees, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two remaining nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. On any subsequent ballot, a nominee shall be elected if they have received a vote on a majority of the legal ballots cast and are one of the nominees receiving the largest number of votes within the number of council members to be elected or remaining to be elected. ~~and 3 or more members of the Council are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest number of votes on the preceding ballot, except where there is a tie. When 2 or fewer members of the Council are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are members of the Council yet to be elected, and must cast each vote for a different nominee.~~ This procedure shall be repeated until all vacancies have been filled.

(Modify Bylaws)

Testimony was heard in unanimous support. Online testimony is limited, with one member offering alternate language for the term “BOTH” to be replaced with “ALL TIED” in 3.4.2.1.2 and 3.4.2.2, which was supported by the authors of the report and one other member. Your Reference Committee recommends that CCB Report 02 be adopted in lieu of the original report.

(19) COUNCIL ON CONSTITUTION AND BYLAWS REPORT
03 - REMOVAL OF OFFICERS, COUNCIL MEMBERS,

COMMITTEE MEMBERS AND SECTION GOVERNING COUNCIL MEMBERS (D-610.997)

RECOMMENDATION A:

That the first recommendation in Council on Constitution and Bylaws Report 03 be referred.

RECOMMENDATION B:

That the second recommendation in Council on Constitution and Bylaws Report 03 be amended by addition and deletion:

That the Councils on Constitution and Bylaws, Long Range Planning and Development and the Ethical and Judicial Affairs and the House develop the procedures to remove a trustee~~,~~ or council member ~~or governing council member~~ for cause.

That the Sections develop the procedures to remove a governing council member for cause with the advice and guidance of the Councils on Constitution and Bylaws, Long Range Planning and Development and the Ethical and Judicial Affairs and the House.

RECOMMENDATION C:

That the third recommendation in Council on Constitution and Bylaws Report 03 be adopted.

RECOMMENDATION D:

That the remainder of the report be filed.

HOD ACTION: The first recommendation in Council on Constitution and Bylaws Report 03 be referred. The second recommendation in Council on Constitution and Bylaws Report 03 be amended by addition and deletion as follows:

That the Sections develop the procedures to remove a governing council member for cause with the advice and guidance of the Councils on Constitution and Bylaws, Long Range Planning and Development and the Ethical and Judicial Affairs.

The third recommendation in Council on Constitution and Bylaws Report 03 be adopted.

Remainder of the report filed.

The Council on Constitution and Bylaws recommends that the following recommendations be adopted, that Policy D-610.997 be rescinded, and that the remainder of this report be filed.

1) That our AMA Bylaws be amended by insertion to add the following provisions. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting:

3. Officers

***

3.6 Vacancies.

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3.6.4 Absences. If an officer misses 6 consecutive regular meetings of the Board, this matter shall be reported to the House of Delegates by the Board of Trustees and the office shall be considered vacant. The vacancy shall be filled as provided in Bylaw 3.6.1 or Bylaw 3.6.3.

3.6.5 Removal for Cause. Any officer may be removed for cause in accordance with procedures established by the House of Delegates.

6. Councils

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6.0.1.4 Removal. A Council member may be removed for cause in accordance with procedures approved by the House of Delegates.

7. Sections

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7.0.3.4 Removal. A Governing Council member may be removed for cause in accordance with procedures approved by the House of Delegates.

(Modify Bylaws)

2) That the Councils on Constitution and Bylaws, Long Range Planning and Development and the Ethical and Judicial Affairs and the House develop the procedures to remove a trustee, council member or governing council member for cause. (Directive to Take Action)

3) That the Election Committee address the need for policy to remove candidates who are found to violate AMA policy G-610.090, AMA Election Rules and Guiding Principles. (Directive to Take Action)

Testimony was mixed, with several calls for referral and amendments proffered. Testimony was generally in support of the spirit of the report but held that sections' interests are best served by maintaining their independence, and that more detailed procedures should be developed before adopting the proposed bylaws changes. Online testimony was similarly mixed. Because the overwhelming majority of testimony in opposition felt the report was "putting the cart before the horse", your Reference Committee recommends that resolution 1 be referred, resolution 2 be adopted in lieu of the original language, and resolution 3 be adopted.

(20) RESOLUTION 001 - USING PERSONAL AND BIOLOGICAL DATA TO ENHANCE PROFESSIONAL WELLBEING AND REDUCE BURNOUT

RECOMMENDATION A:

That the first resolve in Resolution 001 be amended by addition and deletion as follows:

Our American Medical Association will monitor and report on the research regarding technology, measures, and effective use of personal and biological data to assess professional workforce wellbeing and inform organizational interventions to mitigates burnout.

Our AMA will develop ethical guidelines on the collection, use, and protection of personal and biological data obtained to improve professional workforce wellbeing.

RECOMMENDATION C:

That Resolution 001 be adopted as amended.

HOD ACTION: Resolution 001 adopted as amended.

RESOLVED, that our American Medical Association monitor and report on the research regarding technology, measures, and effective use of personal and biological data which supports professional workforce wellbeing and mitigates burnout (Directive to Take Action);

RESOLVED, that our AMA develop ethical guidelines on the collection, use, and protection of personal and biological data for the professional workforce (Directive to Take Action)

Testimony was heard in unanimous support including for a proffered amendment. Online testimony is limited but also in unanimous support. Your Reference Committee recommends that Resolution 001 be adopted as amended.

(21) RESOLUTION 003 - AMENDMENTS TO AMA BYLAWS TO ENABLE MEDICAL STUDENT LEADERSHIP CONTINUITY

RECOMMENDATION A:

That Resolution 003 be amended by <u>addition and deletion</u> as follows:

Our American Medical Association will modify the current 90-day post-graduation eligibility provisions in AMA Bylaws 3.5.6.3, 6.11, 7.3.2, 7.7.3.1, and 7.10.3.1 to allow medical students to serve on the Medical Student Section Governing Council, on the AMA Board of Trustees, on AMA Councils, and as Section Representatives on other Governing Councils for up to 200 days after graduation and not extending past the Annual Meeting following graduation.

RECOMMENDATION B:

That Resolution 003 be <u>adopted as amended</u>.

HOD ACTION: Resolution 003 <u>adopted as amended.</u>

RESOLVED, that our American Medical Association amend AMA Bylaws 3.5.6.3, 6.11, 7.3.2, 7.7.3.1, and 7.10.3.1 to allow medical students to serve on the Medical Student Section Governing Council, on the AMA Board of Trustees, on AMA Councils, and as Section Representatives on other Governing Councils for up to 200 days after graduation. (Modify Bylaws)

Testimony was heard in general support including an amendment for clarity. Online testimony is in unanimous support. Your Reference Committee recommends that Resolution 003 be adopted as amended.

(22) RESOLUTION 012 - ETHICAL PRICING PROCEDURES THAT PROTECT INSURED PATIENTS

RECOMMENDATION A:

That the first resolve of Resolution 012 be amended by addition and deletion as follows:

Our American Medical Association advocates for policies that limit the cost of ~~a~~ medications or durable medical equipment to an insured patient with coverage to the lower range of prices that a non-covered patient can achieve at cash price either before or after application of a non-manufacturer's free discount card (such as GoodRx).

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 012 be adopted as amended.

HOD ACTION: Resolution 012 adopted as amended.

RESOLVED, that our American Medical Association advocate for policies that limit the cost of a medication to an insured patient with medication coverage to the lower range of prices that a non-covered patient can achieve at cash price either before or after application of a non-manufacturer's free discount card (such as GoodRx) (Directive to Take Action)

Our AMA will write a letter to lawmakers and other pertinent stakeholders describing the ethical dilemma of the medication pricing process and how it adversely affects insured patients.

Testimony was heard in unanimous support. One proffered amendment was added to include ethical pricing of durable medical equipment, as this was felt to be germane to the intent of the resolution. Testimony also mentioned including medical services in this resolution; however, due to the inherent nuances of referrals to medical services, it was felt to be not germane to the original topic of the resolution. Online testimony is limited but also in unanimous support. Your Reference Committee recommends that Resolution 012 be adopted as amended.

(23) RESOLUTION 015 - HEALTH AND RACIAL EQUITY IN MEDICAL EDUCATION TO COMBAT WORKFORCE DISPARITIES

RECOMMENDATION A:

That the first resolve of Resolution 015 be amended by addition and deletion as follows:

Our American Medical Association will engage partners to track the prevalence of attending physicians' and trainees' dismissals and remedial interventions, based on race, gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities.

Our AMA will engage partners to study and report back how to effectively support underrepresented groups in medicine to level the playing field for those most affected by bias and historical harms.

Our AMA will work with partners to make recommendations on a review and appeals process that will enable physicians and trainees to receive a fair and equitable due process in defense of alleged shortcomings.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 015 be adopted as amended.

HOD ACTION: Resolution 015 adopted as amended.

RESOLVED, that our American Medical Association further study and track the prevalence of attending physicians' and trainees' dismissals and remedial interventions, based on race, gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities (Directive to Take Action)

RESOLVED, that our AMA engage stakeholders to study and report back how to effectively support underrepresented groups in medicine to level the playing field for those most affected by bias and historical harms (Directive to Take Action)

RESOLVED, that our AMA work with stakeholders to make recommendations on a review and appeals process that will enable physicians and trainees to receive a fair and equitable due process in defense of alleged shortcomings. (Directive to Take Action)

Testimony was heard strongly in favor. One Council testified that it would not be feasible for the AMA to elicit the data for this study on its own. Therefore, our reference committee recommends engaging with partners to accomplish this goal. An amendment was proffered that the term "stakeholders" be replaced with "partners" in recognition of the

effort to address adverse connotations and to align the resolution's language with CDC policy. Online testimony is in general support with one delegation recommending that AMA policies D-295.963, "Continued Support for Diversity in Medical Education," and H200.951, "Strategies for Enhancing Diversity in the Physician Workforce," be reaffirmed in place of Resolution 015. Your Reference Committee recommends that Resolution 015 be adopted as amended.

(24) RESOLUTION 017 - ADDRESSING THE HISTORICAL INJUSTICES OF ANATOMICAL SPECIMEN USE

RECOMMENDATION A:

That the first resolve of Resolution 017 be amended by addition as follows:

1RESOLVED, that Our American Medical Association advocate to AAMC (Association of American Medical Colleges), AACOM (American Association of Colleges of Osteopathic Medicine),and other appropriate bodies for the return of human remains to living family members or Tribes in the case of American Indian/Alaska Native specimens, or, if none exist, the burial of anatomical specimens older than 2 years where consent for permanent donation cannot be proven, with Tribal consultation in the case of American Indian/Alaska Native specimens to ensure that all Tribal burial protocols are followed (Directive to Take Action)

RECOMMENDATION B:

That the second resolve of Resolution 017 be amended by addition as follows:

2RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US review their anatomical collections for remains of American Indian, Hawaiian Native, and Alaska Native remains and immediately return remains and skeletal collections to tribal governments, as required by laws such as the Native American Graves and Repatriation Act, and that our AMA encourage advocacy for federal funds and technical assistance for repatriation (Directive to Take Action);

RECOMMENDATION C:

That Resolution 017 be amended by addition of a new third resolve as follows:

3RESOLVED, that our AMA recognize the disproportionate impact that anatomical specimen collections have had on American Indian, Hawaiian, Alaska Native, Black American, individuals with disabilities, and other historically marginalized groups.

RECOMMENDATION D:

That the original seventh resolve of Resolution 017 be referred.

RECOMMENDATION E:

That the original eighth resolve of Resolution 017 be amended by addition and deletion as follows:

8RESOLVED, that our AMA believes that, for purpose of differentiation and clarity, anatomical specimens, tissues and other human material that were collected and maintained for purposes of diagnosis and compliance under Clinical Laboratory Improvement Act (CLIA) where informed consent for such has been obtained ~~are consistent with the goals of this resolution~~, and that biospecimens donated for research, education, and transplantation where ~~with~~ informed consents of donors (or if deceased, ~~if available,~~ next of kin if available ~~if deceased~~) for such has been obtained ~~are consistent with the goals of this~~

~~resolution~~, as such materials can advance medical knowledge, improve the quality of healthcare and save lives.

RECOMMENDATION F:

That Resolution 017 be adopted as <u>amended</u>.

HOD ACTION: That the original seventh resolve of Resolution 017 be <u>referred</u> and that the remainer of Resolution 017 <u>adopted as amended.</u>

1RESOLVED, that Our American Medical Association advocate to AAMC (Association of American Medical Colleges) and other appropriate bodies for the return of human remains to living family members, or, if none exist, the burial of anatomical specimens older than 2 years where consent for permanent donation cannot be proven (Directive to Take Action);

2RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US review their anatomical collections for remains of American Indian, Hawaiian Native, and Alaska Native remains and immediately return remains and skeletal collections to tribal governments; as required by laws such as the Native American Graves and Repatriation Act (Directive to Take Action);

3RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US review their anatomical collections for remains of Black and Brown people and other minority groups, and return remains and skeletal collections to living family members, or, if none exist, then respectful burial of anatomical specimens or remains (Directive to Take Action);

4RESOLVED, that Our AMA seek legislation or regulation that requires the return of anatomic specimens of American Indian, Hawaiian Natives, Alaskan Natives and other minority groups (Directive to Take Action);

5RESOLVED, that Our AMA support the creation of a national anatomical specimen database that includes registry demographics (New HOD Policy);

6RESOLVED, that our AMA study and develop recommendations regarding regulations for ethical body donations including, but not limited to guidelines for informed and presumed consent; care and use of cadavers, body parts, and tissue (Directive to Take Action);

~~7RESOLVED, that our AMA amend policy 6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors should be amended as follows:~~

~~Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:~~

~~(a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.~~
~~(b) Has been developed in consultation with the population among whom it is to be carried out.~~
~~(c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.~~

~~Unless there are data that suggest a positive effect on donation, n Neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.(Modify Current HOD Policy)~~

8RESOLVED, that our AMA believes that, for purpose of differentiation and clarity, anatomical specimens, tissues and other human material that were collected and maintained for purposes of diagnosis and compliance under Clinical Laboratory Improvement Act (CLIA) where informed consent has been obtained are consistent with the goals of this resolution, and that 28 biospecimens donated for research, education, and transplantation with informed consents of donors (or, if available, next of kin if deceased) are consistent with the goals of this resolution as such materials can advance medical knowledge, improve the quality of healthcare and save lives. (New HOD Policy)

Testimony was mixed but with the majority in support as amended. Opposition generally favored referral back for further study due to the nuance of the subject matter. Proffered amendments focused on clarifying informed consent, special considerations for the remains of Native peoples/Indigenous peoples/American Indians, and the extraction of lines 9-22 (citing that organ and tissue donation should be exempt from this resolution). Online testimony is mixed but limited. Your Reference Committee recommends that the 7th resolve of Resolution 017 be referred, and that all other resolves be adopted as amended.

(25) RESOLUTION 019 - SUPPORTING THE HEALTH OF OUR DEMOCRACY

RECOMMENDATION A:

That the first resolve of Resolution 019 be amended by <u>deletion</u> as follows:

1. Our American Medical Association supports policies that ensure safe and equitable access to voting and opposes the institutional barriers to the process of voter registration.

2. Our AMA encourages physicians and medical trainees to vote, eliminate barriers to their participation in the electoral process, and support their and other healthcare workers' engagement in all voter registration efforts in healthcare settings, including emergency absentee ballot

procedures for qualifying patients, visitors, and healthcare workers

RECOMMENDATION C:

That Resolution 019 be <u>adopted as amended.</u>

HOD ACTION: Resolution 019 <u>adopted as amended.</u>

RESOLVED, that our American Medical Association support policies that ensure safe and equitable access to voting and opposes the institutional barriers to both the process of voter registration and the act of casting a vote (New HOD Policy)

RESOLVED, that our AMA encourage physicians and medical trainees to vote, oppose barriers to their participation in the electoral process, and support their and other healthcare workers' engagement in nonpartisan voter registration efforts in healthcare settings, including emergency absentee ballot procedures for qualifying patients, visitors, and healthcare workers (New HOD Policy)

Our AMA supports the use of independent, nonpartisan commissions to draw districts for both federal and state elections.

Testimony was heard in general support of the second resolve clause but was mixed with respect to resolve clauses one and three. One amendment of the second resolve was proffered. Limited testimony in opposition noted the subject is irrelevant to physicians and goes beyond the scope of the AMA. Online testimony is mixed, as some felt this was outside of the purview of the AMA. However, your Reference Committee agrees with the rationale that this is within the AMA purview, as HOD Policy 440.805, "Support for Safe and Equitable Access to Voting", states that the ability to vote is a non-medical driver of health. This resolution does not contain a directive to take action, and extensive resources are not expected to be used. Your Reference Committee recommends that Resolution 019 be adopted as amended.

RECOMMENDED FOR REFERRAL

(26) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 03 - ESTABLISHING ETHICAL PRINCIPLES
FOR PHYSICIANS INVOLVED IN PRIVATE EQUITY
OWNED PRACTICES

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 03 be referred to CEJA for report at I-24.

HOD ACTION: Recommendation in Council on Ethical and Judicial Affairs Report 03 referred to CEJA for report at I-24.

In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that Opinion 11.2.3, "Contracts to Deliver Health Care Services," be amended by addition and deletion as follows and the remainder of this report be filed:

Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires ~~them to~~ that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions ~~of contracts to deliver health care services before entering into such contracts to ensure that those contracts~~ do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients.

Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards ~~of informed consent and fidelity to patients~~ and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while ~~many~~ some arrangements have the potential to promote desired improvements in care, ~~some~~ other arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere with physician autonomy.

When ~~contracting~~ partnering with entities, or having a representative do so on their behalf, to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the arrangement:

(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;

(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;

(iii) ~~allows~~ ensures the physician can ~~to~~ appropriately exercise professional judgment;

(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;

(v) is transparent and permits disclosure to patients.

(vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians must:

(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.

(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.

(e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.

(Modify HOD/CEJA Policy)

Testimony was heard in strong favor of referral. Although many points in the report were appreciated, testimony cited the need for CEJA to more thoroughly address the harms of private equity's involvement in health care, the ethical responsibility of the decision-making physician when working with private equity in health care, and the effect on junior partners when involving private equity. A key testimonial point was whether it is ever ethical for private equity to invest in health care given their goal of maximizing profits over a short period of time. Testimony reflected the pertinence of a timely response, which is why the reference committee has asked for a response by I-24. Online testimony was mixed. Your Reference Committee recommends that CEJA Report 03 be referred with report at I-24.

(27) RESOLUTION 016 - GUIDING PRINCIPLES FOR THE HEALTHCARE OF MIGRANTS

RECOMMENDATION:

That Resolution 016 be referred.

HOD ACTION: Resolution 016 adopted.

1. Our American Medical Association advocates for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the “Colombo Statement.”

2. Our AMA recognizes that migration status is a social determinant of health.

3. Our AMA affirms the importance of multi-sectoral coordination and inter-country engagement and partnership in enhancing the means of addressing health aspects of migration.

4. Our AMA recognizes that the enhancement of migrants’ health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families.

5. Our AMA recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard.

6. Our AMA recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization’s 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by
a. Ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioral disorders, and sexual and reproductive health care for women, are addressed.
b. Improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems.
c. Ensuring that the social determinants of migrants’ health are addressed through joint,

coherent multisectoral actions in all public health policy responses, especially ensuring promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies, as defined in the Sustainable Development Goals of the United Nations.
d. Ensuring that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.
e. Providing accurate information and dispelling fears and misperceptions among migrant and host populations about the health impacts of migration and displacement on migrant populations and on the health of local communities and health systems.

Testimony was heard in general support of creating an approach to migrant health care as a public health and financial issue. However, there was other testimony that raised issues in scope of treatment, payment for services rendered, managing continuity of care across state lines, and managing incarcerated patients in border towns. Other testimony suggested referral with request for root cause analysis. Further study may be considered to align AMA policy with current WHO policy on this complex issue. There was no online testimony. Your Reference Committee recommends that Resolution 016 be referred.

RECOMMENDED FOR NOT ADOPTION

(28) RESOLUTION 002 - REMOVAL OF THE INTERIM MEETING RESOLUTION COMMITTEE

RECOMMENDATION:

That Resolution 002 be <u>not adopted.</u>

HOD ACTION: Resolution 002 <u>not adopted.</u>

RESOLVED, that our American Medical Association remove the Resolution Committee from Interim Meetings by amending AMA Bylaw B-2.13.3, "Resolution Committee," by deletion as follows:

~~**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); and be it further~~

RESOLVED, that our AMA remove constraints on the scope of business at Interim Meetings, which is regulated by the Resolution Committee, by amending AMA Bylaw B-2.12.1.1, "Business of Interim Meeting," by deletion as follows:

~~**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.~~
(Modify Bylaws)

Mixed testimony was heard. Testimony in favor cited that the resolution would be more democratic. Testimony in opposition argued that the current policy serves to strengthen the quality of resolutions submitted and that there is no need to change a process that works. Online testimony is in opposition. Your Reference Committee recommends that Resolution 002 be not adopted.

(29) RESOLUTION 004 - THE RIGHTS OF NEWBORNS THAT SURVIVE ABORTION

RECOMMENDATION:

That Resolution 004 be <u>not adopted.</u>

HOD ACTION: Resolution 004 <u>not adopted.</u>

RESOLVED, that our American Medical Association amend the current policy right for an abortion to “a woman’s right to abortion as only the right to terminate the pregnancy" (Modify Current HOD Policy)

RESOLVED, a newborn that survives an abortion procedure has a right to reasonable medical care. (New HOD Policy)

Testimony was heard in strong opposition. A primary concern was that the resolution would perpetuate harmful misinformation. Online testimony is in general opposition. Your Reference Committee recommends that Resolution 004 be not adopted.

(30) RESOLUTION 005 - AMA EXECUTIVE VICE PRESIDENT

RECOMMENDATION:

That Resolution 005 be <u>not adopted.</u>

HOD ACTION: Resolution 005 <u>not adopted.</u>

RESOLVED, that our American Medical Association delete the AMA Board of Trustees Duties and Privileges Code B-5.3.6.4 as follows:
~~No individual who has served as an AMA officer or trustee shall be selected or serve as Executive Vice President until three years following completion of the term of the AMA office.”~~(Modify Bylaws)

Testimony was divided, with the majority in opposition. An amendment was proposed that Board members who apply for the position of Executive Vice President should resign immediately from the Board. Testimony in support agreed that all qualified candidates should be available for consideration, while opposing testimony warned about creating

conflicts of interest, citing a past event that led to the creation of the current policy. Online testimony is also mixed. Due to the perception of bias with the timing of this resolution being presented to the HOD during the time of an anticipated EVP change. Your Reference Committee recommends that Resolution 005 be not adopted.

(31) RESOLUTION 006 – TREATMENT OF FAMILY MEMBERS

RECOMMENDATION:

That Resolution 006 be <u>not adopted.</u>

HOD ACTION: Resolution 006 <u>not adopted.</u>

RESOLVED, that our American Medical Association asks CEJA to review and revise the current code of ethics as it relates to treating family members (Directive to Take Action)

RESOLVED, that our AMA ask CEJA to report back to the HOD on this issue at the next interim meeting I-24.

Testimony was limited but mixed. There was general disagreement on the clarity and sufficiency of the guidelines. Online testimony was in general support with one amendment to include “treating <u>friends, colleagues, and</u> family members”. CEJA reviewed this issue in 2016, and the *Code* already allows physicians to treat family members in emergency situations and for short-term, minor problems. Your Reference Committee recommends that Resolution 006 be not adopted.

(32) RESOLUTION 023 - CHANGE HEALTHCARE SECURITY LAPSE—THE FBI MUST INVESTIGATE

RECOMMENDATION:

Resolution 023 be <u>not adopted.</u>

HOD ACTION: Resolution 023 <u>not adopted.</u>

Resolved, that our American Medical Association seek a directed investigation by appropriate authorities of the Change Healthcare cybersecurity breach that defines the cause, so as to minimize the chance of a future breach, as well as to determine any penalties for negligence, should that be a factor in the current episode (Directive to Take Action);

Resolved, that our American Medical Association monitor all ongoing investigations of the Change Healthcare cybersecurity breach with report back at Interim 2024, with recommendations as to further action the AMA itself should pursue (Directive to Take Action).

No testimony was heard. There is also no online testimony. Your Reference Committee recommends that late Resolution 23 be not adopted.

RECOMMENDATION FOR REAFFIRMATION IN LIEU OF

(33) RESOLUTION 007 - AMA SUPPORTS A STRATEGY FOR ELIMINATING NUCLEAR WEAPONS

RECOMMENDATION:

That existing AMA policies H-520.999, "Opposition to Nuclear War," H-520.988, "Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction," H-520.994, "Nuclear Test Ban," and D-440.972, "Safety from Nuclear Weapons and Medical Consequences of Nuclear War" be reaffirmed in lieu of Resolution 007.

Reaffirm the following AMA policies in Lieu of Resolution 007:

H-520.999, Opposition to Nuclear War
H-520.988, Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction,
H-520.994, Nuclear Test Ban
D-440.972, Safety from Nuclear Weapons and Medical Consequences of Nuclear War

RESOLVED, that our American Medical Association calls for the United States to renounce the option to be the first country to use nuclear weapons ("first use") during a conflict (Directive to Take Action)

RESOLVED, that our AMA supports a process whereby multiple individuals, rather than solely the President, are required to approve a nuclear attack, while still allowing a swift response when needed (New HOD Policy)

RESOLVED, that our AMA calls on the US government to cancel plans to rebuild its entire nuclear arsenal and instead to reassess its true strategic needs for the types and numbers of nuclear weapons and delivery systems. (Directive to Take Action)

Testimony was mixed. Testimony in favor stated that nuclear weapons constitute a public health concern and, therefore, are within the purview of the AMA. Testimony in opposition noted that this matter is outside of the scope of the AMA and that existing policy should be reaffirmed instead of supporting this resolution. Online testimony was in general support. Your Reference Committee recommends that current AMA policies H-520.999, "Opposition to Nuclear War," H-520.988, "Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction," H-520.994, "Nuclear Test Ban," and D-440.972, "Safety from Nuclear Weapons and Medical Consequences of Nuclear War" be reaffirmed in lieu of the Resolution 007.

Madam Speaker, this concludes the report of Reference Committee on Amendments to Constitution and Bylaws. I would like to thank Dr. Edward Tuohy, Dr. Theodore Jones, Dr. Candace Keller, Dr. Barbara Weissman, Dr. Divya Srivastava and Kimberly Ibarra and all those who testified before the committee.

Edward Tuohy, MD
Soc. Cardiology, Angiography and Intervention

Theodore Jones, MD
Michigan State Medical Society

Candace Keller, MD, MPH
American Soc. of Anesthesiologists

Barbara Weissman, MD
California Medical Association

Divya Srivastava, MD
American College of Mohs Surgery

Kimberly Ibarra
Medical Students Section

Emily Briggs, MD
American Academy of Family Physicians
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-24)

Report of Reference Committee A

Debra Perina, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. CMS Report 2 -- Improving Affordability of Employment-Based Health Coverage
2. CMS Report 7 -- Ensuring Privacy in Retail Health Care Settings
3. Resolution 110 – Coverage for Shoes and Shoe Modifications for Pediatric Patients Who Require Lower Extremity Orthoses
4. Resolution 112 – Private and Public Insurance Coverage for Adaptive Sports Equipment Including Prostheses and Orthoses
5. Resolution 116 – Increase Insurance Coverage for Follow-Up Testing After Abnormal Screening Mammography

RECOMMENDED FOR ADOPTION AS AMENDED

6. CMS Report 3 -- Review of Payment Options for Traditional Healing Services
7. CMS Report 8 -- Sustainable Payment for Traditional Healing Services
8. Resolution 101 -- Infertility Coverage
9. Resolution 103 – Medicare Advantage Plans
10. Resolution 106 – Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum
    Resolution 118 – Public and Private Payer Coverage of Diagnostic Interventions Associated with Colorectal Cancer Screening and Diagnosis
11. Resolution 109 – Coverage for Dental Services Medically Necessary for Cancer Care
12. Resolution 115 – Payments by Medicare Secondary or Supplemental Plans

RECOMMENDED FOR ADOPTION IN LIEU OF

13. Resolution 105 – Medigap Patient Protections
    Resolution 111 – Protections for “Guaranteed Issue” of Medigap Insurance and Traditional Medicare

RECOMMENDED FOR REFERRAL

14. Resolution 102 – Medicaid & CHIP Benefit Improvements
15. Resolution 104 – Medicaid Estate Recovery Reform

16. Resolution 113 – Support Prescription Medication Price Negotiation

RECOMMENDED FOR REFERRAL FOR DECISION

17. Resolution 117 – Insurance Coverage for Gynecologic Oncology Care

RECOMMENDED FOR NOT ADOPTION

18. Resolution 107 – Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies
19. Resolution 108 – Requiring Payment for Physician Signatures
20. Resolution 114 – Breast Cancer Screening/Clinical Breast Exam Coverage

Amendments

If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) CMS REPORT 2 -- IMPROVING AFFORDABILITY OF EMPLOYMENT-BASED HEALTH COVERAGE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Recommendations in Council on Medical Service Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 2 referred.

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 103-A-23, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-165.828[1] by addition and deletion to read:

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 the ~~level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage~~ maximum percentage of income they would be required to pay towards premiums after accounting for subsidies ~~in~~ for an Affordable Care Act (ACA) marketplace~~s~~ benchmark plan. (Modify HOD Policy)

2. That our AMA amend Policy H-165.843 by addition and deletion to read:

Our AMA encourages employers to:
a) promote greater individual choice and ownership of plans;
b) implement plans to improve affordability of premiums and/or cost-sharing, especially expenses for employees with lower incomes and those who may qualify for Affordable Care Act marketplace plans based on affordability criteria;
c) ~~help employees determine if their employer coverage offer makes them ineligible or eligible for federal marketplace subsidies~~ provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of employer-sponsored insurance;
~~b~~d) ~~enhance employee education regarding available health plan options and how to choose health plans that meet their needs~~ provide employees with information regarding available health plan options, including the plan's cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs;
~~c~~e) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
~~d~~f) support increased fairness and uniformity in the health insurance market; and
~~e~~g) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (Modify HOD Policy)

3. That our AMA support efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards, like those required of nongroup marketplace plans. (New HOD Policy)

4. That our AMA reaffirm Policy H-165.881, which directs the AMA to pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice and expanded individual selection and ownership of health insurance. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-165.920, which supports individually purchased and owned health insurance coverage as the preferred option, although employer-provided coverage is still available to the extent the market demands it, and other principles related to health insurance. (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony on Council on Medical Service Report 2. A member of the Council on Medical Service introduced the report by noting that although employer-sponsored insurance (ESI) remains the dominant source of health coverage in this country, and most people seem satisfied with it, some workers are paying more for an employer plan than they would pay for subsidized ACA marketplace coverage. The Council member added that Recommendation 1 of Council on Medical Service Report 2 is intended to help these employees, most of whom earn lower incomes, by reducing the threshold that determines whether their ESI offer is deemed affordable, thereby making workers most in need eligible for subsidized marketplace plans.

Referral was suggested by speakers expressing concerns about potential long-term consequences of lowering the affordability threshold, including reductions in revenue for independent physician practices. An amendment to add an additional recommendation, to support completely lifting the affordability firewall, received limited supportive testimony. A member of the Council on Medical Service spoke in opposition to this amendment and defended the report’s incremental approach, stating that eliminating the firewall abruptly and in full could harm ESI stability and significantly increase federal spending. The Council member acknowledged that some speakers want to fully eliminate the affordability threshold while others do not want the threshold lowered at all and opposed referral of this report since the recommendations represent an appropriate middle ground. Your Reference Committee supports the Council’s incremental approach and recommends that Council on Medical Service Report 2 be adopted as amended.

(2) CMS REPORT 7 -- ENSURING PRIVACY IN RETAIL HEALTH CARE SETTINGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Recommendations in Council on Medical Service Report 7 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service 7 adopted and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) will:

(a) support regulatory guidance to establish a privacy wall between the health business and non-health business of retail health care companies to eliminate sharing of protected health information, re-identifiable patient data, or data that could be reasonably be used to re-identify a patient when combined with other data for uses not directly related to patients' medical care;
(b) support the prohibition of Terms of Use that require data sharing for uses not directly related to patients' medical care in order to receive care, while still allowing data sharing where required by law (e.g., infectious disease reporting);
(c) support the separation of consents required to receive care from any consents to share data for non-medical care reasons, with clear indication that patients do not need to sign the data-sharing agreements in order to receive care;
(d) support the prohibition of "clickwrap" contracts for use of a health care service without affirmative patient consent to data sharing;
(e) support the requirement that retail health care companies must use an active opt-in selection for obtaining meaningful consent for data use and disclosure, otherwise the default should be that the patient does not consent to disclosure;
(f) support the requirement that retail health care companies clearly indicate how patients can withdraw consent and request deletion of data retained by the non-health care providing units, which should be by a means no more onerous than providing the initial consent. (New HOD Policy)

2. That our AMA reaffirm Policy D-315.968, which advocates for legislation that aligns mobile health apps and other digital health tools with the AMA Privacy Principles. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-315.962, which supports 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 data. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-480.940, which promotes development of thoughtfully designed, high-quality, clinically validated health care AI that safeguards patients' privacy interests and preserves the security and integrity of personal information. (Reaffirm HOD Policy)
5. Rescind Policy H-315.960, as having been completed with this report. (Rescind HOD Policy)

Testimony on Council on Medical Service Report 7 was strongly supportive. A member of the Council on Medical Service introduced the report by noting that there is confusion surrounding retail health care companies' HIPAA status, as they require patients to read and comprehend several documents together in order to understand their rights. The Council member noted that while online testimony indicated that a large retail health care company recently revised its online terms of use, nothing prevents it from reverting to its previous privacy practices and, therefore, the report recommendations should be adopted to allow consideration across a variety of companies and situations. Therefore, your Reference Committee recommends that the recommendations in the Council on Medical Service Report 7 be adopted, and the remainder of the report be filed.

(3) RESOLUTION 110 -- COVERAGE FOR SHOES AND SHOE MODIFICATIONS FOR PEDIATRIC PATIENTS WHO REQUIRE LOWER EXTREMITY ORTHOSES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 110 be <u>adopted</u>.

HOD ACTION: Resolution 110 <u>adopted</u>.

RESOLVED, that our American Medical Association support coverage by all private and government insurance companies for pediatric footwear suitable for use with lower extremity orthoses and medically necessary shoe modifications. (New HOD Policy)

Your Reference Committee heard testimony in strong support of Resolution 110. The testimony emphasized the importance of having appropriate coverage for orthoses and modified shoes to prevent future orthopedic complications. Moreover, for orthoses to work properly and correctly stabilize the lower limbs, the appropriate shoe and/or modified shoe is necessary. Your Reference Committee agreed that modified shoes should not be an out-of-pocket cost since it is directly related to the diagnoses and recommended treatment plan. Therefore, your Reference Committee recommends that Resolution 110 be adopted.

(4) RESOLUTION 112 -- PRIVATE AND PUBLIC INSURANCE COVERAGE FOR ADAPTIVE SPORTS EQUIPMENT INCLUDING PROSTHESES AND ORTHOSES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 112 be adopted.

HOD ACTION: Resolution 112 adopted.

RESOLVED, that our American Medical Association recognizes activity-specific adaptive sports and exercise equipment as assistive devices that are integral to the health maintenance of persons with disabilities in accordance with national exercise guidelines (New HOD Policy); and be it further

RESOLVED, that our AMA recognizes activity-specific adaptive sports and exercise equipment, such as activity-specific prostheses and orthoses, as medical devices that facilitate independence and community participation (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for coverage by all private and public insurance plans for activity-specific adaptive sports and exercise equipment for eligible beneficiaries with disabilities in order to promote health maintenance and chronic disease prevention. (Directive to Take Action)

Your Reference Committee heard exclusively supportive testimony on Resolution 112 and the importance of activity-specific adaptive equipment to the health of people with disabilities. Speakers emphasized that sports activities provide community and social interaction and that coverage of equipment enabling participation by people with disabilities aligns with AMA equity goals. Accordingly, your Reference Committee recommends that Resolution 112 be adopted.

(5) RESOLUTION 116 -- INCREASE INSURANCE COVERAGE FOR FOLLOW-UP TESTING AFTER ABNORMAL SCREENING MAMMOGRAPHY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 116 be adopted.

HOD ACTION: Resolution 116 adopted.

RESOLVED, that our American Medical Association support public and private payer coverage for screening mammography and follow-up testing after an abnormal screening mammography; and be it further

RESOLVED, that our AMA advocate for legislation that ensures adequate funding for mammography services and follow-up testing after an abnormal screening mammography; and be it further

RESOLVED, that our AMA promote health care community education and public awareness of services provided for women of low income.

Testimony was unanimously supportive of Resolution 116. Speakers pointed out that many people cannot afford appropriate follow-up testing when abnormalities are identified by screening mammography, and that such testing should be covered by insurers. Your Reference Committee recommends that Resolution 116 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(6) CMS REPORT 3 -- REVIEW OF PAYMENT OPTIONS FOR TRADITIONAL HEALING SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Recommendation of Council on Medical Service Report 3 be amended by deletion to read as follows:

1. That our American Medical Association (AMA) amend Policy H-350.976 by addition and deletion, and modify the title by addition, as follows:

Improving Health Care of American Indians and Alaska Natives H-350.976 50

(1) Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
(4) American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
(6) Our AMA ~~support~~ monitor~~ing of~~ Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.

(7) Our AMA support consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.

(~~6~~8) Strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(~~7~~9) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(~~8~~10) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(~~9~~11) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.

(~~10~~12) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.

(~~11~~13) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. (Modify HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

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

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 106-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-350.976 by addition and deletion, and modify the title by addition, as follows:

Improving Health Care of American Indians and Alaska Natives H-350.976 50
(1) Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
(4) American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
(6) Our AMA support monitoring of Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
(7) Our AMA support consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
(~~6~~8) Strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(~~7~~9) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(~~8~~10) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(~~9~~11) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
(~~10~~12) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians and Alaska Natives.

(~~11~~13) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. (Modify HOD Policy)

2. That our AMA reaffirm Policy D-350.996, which states that the AMA will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-200.954, which supports efforts to quantify the geographic maldistribution of physicians and encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-350.949, which encourages state Medicaid agencies to follow the Centers for Medicare & Medicaid Services Tribal Technical Advisory Group's recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-350.977, which supports expanding the American Indian role in their own health care and increased involvement of private practitioners and facilities in American Indian health care through such mechanisms as agreements with Tribal leaders or Indian Health Service contracts, as well as normal private practice relationships. (Reaffirm HOD Policy)

Testimony on Council on Medical Service Report 3 was supportive. A member of the Council on Medical Service introduced the report by noting that since spirituality is now considered a social determinant of health, traditional healing services play a significant role in identifying, evaluating, and working to close health care disparities among American Indian and Alaska Native populations. The Council member added that Section 1115 waivers are the appropriate vehicle for traditional healing services, as they are heavily vetted and also time-limited, which allows for evaluation and course correction. One delegation proffered an amendment to allow the AMA to monitor the Medicaid Section 1115 waivers, rather than just support the monitoring of the waivers. Based on testimony, your Reference Committee recommends that the recommendations in the Council on Medical Service Report 3 be adopted as amended, and the remainder of the report be filed.

(7) CMS REPORT 8 -- SUSTAINABLE PAYMENT FOR COMMUNITY PRACTICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Recommendation of Council on Medical Service Report 8 be amended by addition to read as follows:

1. That our American Medical Association (AMA) support making bonuses for population-based programs accessible to small community practices, without untenable exposure to administrative burden or downside risk, taking into consideration the size of the populations they manage and with a specific focus on improving care and payment for children, pregnant people, and people with mental health conditions, as these groups are often disproportionately covered by Medicaid. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Recommendation of Council on Medical Service Report 8 be amended by addition and deletion to read as follows:

2. That our AMA amend Policy D-400.990 by addition and deletion, and modify the title by addition and deletion, as follows:

Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule ~~Conversion Factors~~ D-400.990
Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from the Medicare Physician Payment Schedule ~~conversion factors~~ and to maintain a ~~fair and appropriate~~ level of payment ~~reimbursement~~ that is sustainable, reflects the full cost of practice, and the value of the care provided, and includes ~~an~~ inflation-based updates; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare Physician Payment ~~professional fee s~~Schedule. (Modify Current HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Recommendation of Council on Medical Service Report 8 be amended by addition and deletion to read as follows:

3. That our AMA amend Policy H-290.976 by addition and deletion, and modify the title by addition and deletion, as follows:

Enhanced ~~S~~CHIP Enrollment, Outreach, and Payment ~~Reimbursement~~ H-290.976
1. It is the policy of our AMA that prior to or concomitant with states' expansion of ~~State~~ Children's Health Insurance Programs (~~S~~CHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of ~~S~~CHIP eligible children, using all available state and federal funds.
2. Our AMA affirms its commitment to advocating for ~~reasonable~~ ~~S~~CHIP and Medicaid payment that is sustainable, reflects the full cost of practice~~,~~ and the value of the care provided, ~~and~~ includes inflation-based updates, ~~reimbursement for its medical providers, defined as at minimum~~ and ~~is~~ pays no less than 100 percent of RBRVS Medicare allowable. (Modify Current HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Recommendation of Council on Medical Service Report 8 be amended by addition and deletion to read as follows:

4. That our AMA amend Policy H-385.921 by addition and deletion as follows:

Health Care Access for Medicaid Patients H-385.921
It is AMA policy that to increase and maintain access to health care for all, payment for physicians ~~providers~~ under ~~for~~ Medicaid, TRICARE, and any other publicly funded insurance plan must be sustainable, reflect the full cost of practice~~,~~ and the value of the care provided, ~~and~~ include inflation-based updates, and ~~is~~ pays no less than ~~at minimum~~ 100 percent of ~~the~~ RBRVS Medicare allowable. (Modify Current HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Recommendations in Council on Medical Service Report 8 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 8 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support making bonuses for population-based programs accessible to small community practices, taking into consideration the size of the populations they manage and with a specific focus on improving care and payment for children, pregnant people, and people with mental health conditions, as these groups are often disproportionately covered by Medicaid. (New HOD Policy)

2. That our AMA amend Policy D-400.990 by addition and deletion, and modify the title by addition and deletion, as follows:

Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule ~~Conversion Factors~~ D-400.990
Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from the Medicare Physician Payment Schedule ~~conversion factors~~ and to maintain a ~~fair and appropriate~~ level of payment ~~reimbursement~~ that is sustainable, reflects the full cost of practice, the value of the care provided, and includes an inflation-based update; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare Physician Payment ~~professional fee s~~Schedule. (Modify Current HOD Policy)

3. That our AMA amend Policy H-290.976 by addition and deletion, and modify the title by addition and deletion, as follows:

Enhanced ~~S~~CHIP Enrollment, Outreach, and Payment ~~Reimbursement~~ H-290.976
1. It is the policy of our AMA that prior to or concomitant with states' expansion of ~~State~~ Children's Health Insurance Programs (~~S~~CHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of ~~S~~CHIP eligible children, using all available state and federal funds.
2. Our AMA affirms its commitment to advocating for ~~reasonable~~ ~~S~~CHIP and Medicaid payment that is sustainable, reflects the full cost of practice, the value of the care provided, and includes inflation-based updates, ~~reimbursement for its medical providers,~~

~~defined as at minimum~~ and is no less than 100 percent of RBRVS Medicare allowable. (Modify Current HOD Policy)

4. That our AMA amend Policy H-385.921 by addition and deletion as follows:

Health Care Access for Medicaid Patients H-385.921
It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be sustainable, reflect the full cost of practice, the value of the care provided, and include inflation-based updates, and is no less than ~~at minimum~~ 100 percent of ~~the~~ RBRVS Medicare allowable. (Modify Current HOD Policy)

5. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to ensure adequate payment for services rendered by private practicing physicians, creating and maintaining a reference document establishing principles for entering into and sustaining a private practice, and issuing a report in collaboration with the Private Practice Physicians Section at least every two years to communicate efforts to support independent medical practices. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-200.949, which supports development of administrative mechanisms to assist primary care physicians in the logistics of their practices to help ensure professional satisfaction and practice sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-285.904, which supports fair out-of-network payment rules coupled with strong network adequacy requirements for all physicians. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-385.986, which opposes any type of national mandatory fee schedule. (Reaffirm HOD Policy)

Testimony on Council on Medical Service Report 8 was strongly supportive. A member of the Council on Medical Service introduced the report by noting that an ideal payment benchmark will reflect the cost of providing care in both the short term and long term while acknowledging risk, variable expenses, an appropriate allocation of fixed costs, and physician work. The Council member confirmed that the Council accepts the addition to Recommendation 1 and the grammatical revisions to Recommendations 2, 3, and 4 as friendly amendments. Therefore, your Reference Committee recommends that the recommendations in Council on Medical Service Report 8 be adopted as amended, and the remainder of the report be filed.

(8) RESOLUTION 101 -- INFERTILITY COVERAGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 101 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association amend Policy H-185.990, "Infertility and Fertility Preservation Insurance Coverage" by addition and deletion to read as follows; and be it further

1. Our AMA advocates for third-party payer health insurance carriers, as well as state and federal initiatives to make available insurance benefits ~~supports federal protections that ensure insurance coverage by all payers~~ for the diagnosis and treatment of recognized ~~male and female~~ infertility and for reproductive and family planning purposes.

2. Our AMA supports payment for fertility preservation therapy services by all payers including 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~~.

3. Our AMA will work with interested organizations to encourage the Indian Health Service to cover infertility diagnostics and treatment for patients seen by or referred through an Indian Health Service, Tribal, or Urban Indian Health Program. (Modify Current HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 101 be deleted.

~~**RESOLVED, that our AMA study the feasibility of insurance coverage for fertility preservation for reasons other than iatrogenic infertility (Directive to Take Action); and be it further**~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 101 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support the review of services defined to be experimental or excluded for payment by the Indian Health Service and for the appropriate bodies to ~~make~~ explore and propose evidence-based recommendations for ~~updated~~ health services coverage. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 101 be adopted as amended.

HOD ACTION: Resolution 101 adopted as amended.

RESOLVED, that our American Medical Association amend Policy H-185.990, "Infertility and Fertility Preservation Insurance Coverage" by addition and deletion to read as follows; and be it further

1. Our AMA ~~advocates for third party payer health insurance carriers to make available insurance benefits~~ supports federal protections that ensure insurance coverage by all payers 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.
3. Our AMA will work with interested organizations to encourage the Indian Health Service to cover infertility diagnostics and treatment for patients seen by or referred through an Indian Health Service, Tribal, or Urban Indian Health Program. (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA study the feasibility of insurance coverage for fertility preservation for reasons other than iatrogenic infertility (Directive to Take Action); and be it further

RESOLVED, that our AMA support the review of services defined to be experimental or excluded for payment by the Indian Health Service and for the appropriate bodies to make evidence-based recommendations for updated health services coverage. (New HOD Policy)

Testimony on Resolution 101 was mixed, with most indicating strong support but one delegation recommending deletion of Resolve 2 as it asks for a study that would be expensive and without clear focus. The same delegation recommended deletion of Resolve 3 as it goes beyond the scope of the remainder of the resolution. Several amendments were proffered by those supporting the resolution to promote an “all-of-the-above” approach to expanding insurance coverage, include reproductive and family planning services, provide educational resources for physicians interested in advocating for expanded coverage, and explore evidence-based recommendations for IHS coverage of fertility services. Therefore, your Reference Committee recommends that Resolution 101 be adopted as amended.

(9) RESOLUTION 103 -- MEDICARE ADVANTAGE PLANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 103 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association encourage that ~~urge the United States Congress and Centers for Medicare and Medicaid Services to take steps to end the upcoding for~~ Medicare Advantage risk adjustment formulas be revised so that claims data is based on the actual cost of providing care ~~plans that results in high subsidies which are unfair to traditional Medicare and burdensome to the public treasury and many beneficiaries~~. (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 103 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~encourages Centers for Medicare and Medicaid Services to~~ provide or create educational materials such as an infographic to compare Traditional Medicare and Medicare Advantage plans ~~improve the attractiveness of Traditional Medicare~~ so that patients are able to make informed choices that best meet their health care needs ~~the option remains robust and available giving beneficiaries greater traditional choices for this option and to seek better care for themselves~~. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 103 be adopted as amended.

HOD ACTION: Resolution 103 adopted as amended.

RESOLVED, that our American Medical Association urge the United States Congress and Center for Medicare and Medicaid Services to take steps to end the upcoding for Medicare Advantage plans that results in high subsidies which are unfair to traditional Medicare and burdensome to the public treasury and many beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA encourages Center for Medicare and Medicaid Services to improve the attractiveness of traditional Medicare so that the option remains robust and available giving beneficiaries greater traditional choices for this option and to seek better care for themselves. (New HOD Policy)

Your Reference Committee heard robust testimony in strong support of Resolution 103. Multiple amendments were proffered by individuals and delegations. The testimony and proffered amendments largely emphasized the need for resources such as educational materials that compare Traditional Medicare and Medicare Advantage so that patients are able to make informed decisions regarding their care. Further, amendments and testimony stated that physicians alone are not responsible for inflating payment via upcoding and that risk adjustment formulas, such as the hierarchical condition category formula, need to reflect the actual cost of providing care.

A member of the Council on Legislation testified in support of the intent of the second Resolve clause to support informed patient choice. Further, a member of the Council on Legislation testified to the amendment to the first Resolve clause which enables the AMA to advocate for policy solutions that reflect the actual costs of providing health care. Testimony was provided in opposition to one of the proffered Resolve clauses requesting a broad report on Medicare Advantage, which was thought to be beyond the purview of the initial issues raised by Resolution 103. Additionally, your Reference Committee agreed that the AMA already has extensive policy on Medicare Advantage payment, prior authorization, marketing, and other practices; therefore, a broad study is not warranted. Further, improving physician payment and ensuring appropriate funding for Medicare is already a centerpiece of AMA federal advocacy efforts. Therefore, your Reference Committee recommends that Resolution 103 be adopted as amended.

(10) RESOLUTION 106 -- INCORPORATING SURVEILLANCE COLONOSCOPY INTO THE COLORECTAL CANCER SCREENING CONTINUUM
RESOLUTION 118 -- PUBLIC AND PRIVATE PAYER COVERAGE OF DIAGNOSTIC INTERVENTIONS ASSOCIATED WITH COLORECTAL CANCER SCREENING AND DIAGNOSIS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 106 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association Policy H-185.960, "Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans" be amended by addition to read as follows:

1. Our AMA supports health plan coverage for the full range of colorectal cancer screening tests.

2. Our AMA will advocate through legislation and/or regulation, as appropriate for adequate payment and the elimination of ~~seek to eliminate~~ cost-sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy that includes a "diagnostic" intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients.

3. Our AMA will seek to eliminate cost-sharing in all health plans for "follow-on" colonoscopies performed for colorectal cancer screening and all associated costs, defined as when other alternative screening tests (i.e., stool- or blood-based tests) are found to be positive.

4. Our AMA will seek to classify follow-up, follow-on, or surveillance colonoscopy after an original screening colonoscopy that required polyp removal as a screening service under the Affordable Care Act preventive services benefit and will seek to eliminate patient cost sharing in all health plans under such circumstances. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 106 be adopted as amended in lieu of Resolution 118.

HOD ACTION: Resolution 106 adopted as amended in lieu of Resolution 118.

Resolution 106

RESOLVED, that our American Medical Association Policy H-185.960, "Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans" be amended by addition to read as follows:

1. Our AMA supports health plan coverage for the full range of colorectal cancer screening tests.

2. Our AMA will seek to eliminate cost-sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy that includes a "diagnostic" intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients.

3. Our AMA will seek to eliminate cost-sharing in all health plans for "follow-on" colonoscopies performed for colorectal cancer screening and all associated costs, defined as when other alternative screening tests are found to be positive.

4. Our AMA will seek to classify follow-up, follow-on, or surveillance, colonoscopy after an original screening colonoscopy that required polyp removal as a screening service under the Affordable Care Act preventive services benefit and will seek to eliminate patient cost sharing in all health plans under such circumstances. (Modify Current HOD Policy)

Resolution 118

RESOLVED, that our American Medical Association advocate (through legislation and/or regulation, as appropriate) for adequate payment and the elimination of cost sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy with a "diagnostic" intervention (i.e., the removal of a polyp or biopsy of a mass) and follow-up colonoscopy after a positive stool-based test.

Testimony strongly supported amendments jointly submitted by the authors of Resolutions 106 and 118 that combined the intent of these resolutions into amended Resolution 106. Speakers emphasized the importance of eliminating cost-sharing for "follow-on" colonoscopies, polyp removal and biopsy, and surveillance colonoscopies since these procedures are critical preventive services that save lives. Your Reference Committee recommends adoption of Resolution 106 as amended in lieu of Resolution 118.

(11) RESOLUTION 109 -- COVERAGE FOR DENTAL SERVICES MEDICALLY NECESSARY FOR CANCER CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 109 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association supports that oral examination and dental services prior to and following the administration of radiation, chemotherapy, ~~chimeric antigen receptor (CAR) T-cell therapy~~ immunotherapy, stem cell transplantation, cell and gene therapies, and high-dose bone-modifying agents for the treatment of hematologic and oncologic disorders ~~cancer~~ are part of medically necessary care (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 109 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA will advocate that ~~all insurers~~ public and private payers cover medically necessary oral examination and dental services prior to the administration of and resulting as a complication of radiation, chemotherapy, chimeric antigen receptor (CAR) T-cell therapy and high-dose bone-modifying agents, and/or surgery for all cancer ~~of the head and neck region~~. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 109 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 109 be changed to read as follows:

COVERAGE FOR DENTAL SERVICES MEDICALLY NECESSARY FOR HEMATOLOGY AND ONCOLOGY ~~CANCER~~ CARE

HOD ACTION: Resolution 109 adopted as further amended by addition and deletion with a change in title.

RESOLVED, that our American Medical Association supports that oral examination and dental services prior to and following the administration of radiation, chemotherapy, ~~chimeric antigen receptor (CAR) T-cell therapy~~ immunotherapy, stem cell transplantation, cell and gene therapies, surgery, and high-dose bone-modifying agents for the treatment of hematologic and oncologic disorders ~~cancer~~ are part of medically necessary care (New HOD Policy); and be it further

RESOLVED, that our AMA will advocate that ~~all insurers~~ all public and private payers cover medically necessary oral examination and dental services prior to the administration of and resulting as a complication of radiation, chemotherapy, ~~chimeric antigen receptor (CAR) T-cell therapy~~ immunotherapy, stem cell transplantation, cell and gene therapies, surgery, and high-dose bone-modifying agents, ~~and/or surgery~~ for all ~~cancer of the head and neck region~~ hematologic and oncologic disorders. (Directive to Take Action)

RESOLVED, that our American Medical Association supports that oral examination and dental services prior to and following the administration of radiation, chemotherapy, chimeric antigen receptor (CAR) T-cell therapy and high-dose bone-modifying agents for the treatment of cancer are part of medically necessary care (New HOD Policy); and be it further

RESOLVED, that our AMA will advocate that all insurers cover medically necessary oral examination and dental services prior to the administration of and resulting as a complication of radiation, chemotherapy and/or surgery for all cancer of the head and neck region. (Directive to Take Action)

Testimony on Resolution 109 was strongly supportive, stressing the importance of this issue as poor dental care can be a contraindication for surgery. One individual supported the resolution based on the fact that it will not contribute to scope creep. Two delegations proffered amendments to allow consideration of hematologic and oncologic disorders beyond head and neck cancers and therapies such as chimeric antigen receptor (CAR) T-cell therapy and high-dose bone-modifying agents. One individual offered a suggested amendment to address coverage by payers such as Indian Health

Service. These were all considered friendly amendments by the authors. Therefore, your Reference Committee recommends that Resolution 109 be adopted as amended.

(12) RESOLUTION 115 -- PAYMENTS BY MEDICARE SECONDARY OR SUPPLEMENTAL PLANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 115 be deleted.

~~**RESOLVED, that our AMA will report on the status of this resolution and Policies H-390.839 and D-390.984 at the 2025 Annual Meeting. (Directive to Take Action)**~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends Resolution 115 be adopted as amended.

HOD ACTION: Resolution 115 adopted as amended.

RESOLVED, our American Medical Association will advocate for legislation that would mandate that all health plans cover Medicare secondary claims regardless of the provider participating in the secondary health plan (Directive to Take Action); and be it further

RESOLVED, that our AMA will report on the status of this resolution and Policies H-390.839 and D-390.984 at the 2025 Annual Meeting. (Directive to Take Action)

Testimony was largely supportive of the first Resolve of Resolution 115. Four individuals and three delegations indicated that this is a significant problem that may create undue financial burden and access issues for patients, as it amounts to another take on surprise billing. A member of the Council on Medical Service recommended the deletion of the second Resolve since proceedings of past HOD meetings and follow-up from HOD actions are available on the HOD archives website. Therefore, your Reference Committee recommends that Resolution 115 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(13) RESOLUTION 105 -- MEDIGAP PATIENT PROTECTIONS
RESOLUTION 111 -- PROTECTIONS FOR "GUARANTEE ISSUE" OF MEDIGAP INSURANCE AND TRADITIONAL MEDICARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 105 be adopted in lieu of Resolution 105 and Resolution 111.

RESOLVED, that our American Medical Association support annual open enrollment periods and guaranteed lifetime enrollment eligibility for Medigap plans (New HOD Policy); and be it further

RESOLVED, that our AMA extend advocacy efforts to ensure federal "guaranteed issue" protections are enacted, allowing beneficiaries the freedom to switch from Medicare Advantage to Traditional Medicare plans without facing prohibitive barriers (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for extending modified community rating regulations to Medigap supplemental insurance plans, similar to those enacted under the Affordable Care Act for commercial insurance plans (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to expand access to Medigap plans to all individuals who qualify for Medicare benefits (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to improve the affordability of Medigap supplemental insurance for lower income Medicare beneficiaries. (New HOD Policy)

HOD ACTION: Alternate Resolution 105 adopted in lieu of Resolution 105 and Resolution 111.

Resolution 105

RESOLVED, that our American Medical Association support annual open enrollment periods and guaranteed lifetime enrollment eligibility for Medigap plans (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for extending modified community rating regulations to Medigap supplemental insurance plans, similar to those enacted under the Affordable Care Act for commercial insurance plans (Directive to Take Action); and be it further RESOLVED, that our AMA support efforts to expand access to Medigap policies to all individuals who qualify for Medicare benefits (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to improve the affordability of Medigap supplemental insurance for lower income Medicare beneficiaries. (New HOD Policy)

Resolution 111

RESOLVED, that our American Medical Association pursue all necessary legislative and administrative measures to ensure that Medicare beneficiaries have the freedom to switch back to Traditional Medicare and obtain Medigap insurance under federal "guaranteed issue" protections. (Directive to Take Action)

Your Reference Committee heard overwhelming testimony in support of Resolutions 105 and 111. Two delegations recommended referral to allow study of the potential adverse selection hazard introduced by individuals with high risk diseases migrating to Medigap. The authors of 105 indicated that adverse selection is only a risk if cost-sharing varies considerably between Medicare Advantage and Traditional Medicare – and that is not the case. A member of the Council on Medical Service stressed the importance of strengthening Medigap as an alternative option to facilitate patients' ability to transition from Medicare Advantage to Traditional Medicare. The Council member then proffered an amendment to combine Resolutions 105 and 111 and align Medigap policy with existing policy supporting ACA discrimination prohibitions, which was supported by the Council on Legislation plus six delegations, including the authors of each resolution. For these reasons, your Reference Committee recommends Alternate Resolution 105 be adopted in lieu of Resolution 105 and Resolution 111.

RECOMMENDED FOR REFERRAL

(14) RESOLUTION 102 -- MEDICAID & CHIP BENEFIT IMPROVEMENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 102 be referred.

HOD ACTION: Resolution 102 adopted as amended by addition and deletion.

RESOLVED, that our American Medical Association amend H-185.929 Hearing Aid Coverage by addition as follows; and be it further

Hearing Aid Coverage H-185.929[10]

10) Our AMA ~~advocates that~~ works with interested state medical associations to support coverage of hearing exams, hearing aids, cochlear implants, and aural rehabilitative services by appropriate physician-led teams, ~~be covered~~ in ~~all~~ Medicaid and CHIP programs and any new public payers. (Modify Current HOD Policy)

RESOLVED, that our AMA ~~advocate that~~ work with interested state medical associations to support coverage of routine comprehensive vision exams and visual aids (including eyeglasses and contact lenses) be covered in all Medicaid and CHIP programs and by any new public payers (Directive to Take Action); and be it further

RESOLVED, that our AMA amend H-330.872, "Medicare Coverage for Dental Services" by addition and deletion as follows.

Medicare Coverage for Dental Services H-330.872
Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare, and Medicaid, CHIP, and other public payer beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease among in the Medicare, Medicaid, CHIP, and other public payer beneficiaries population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the among Medicare, Medicaid, CHIP, and other public payer beneficiaries population, and the impact of expanded dental coverage on health care costs and utilization. (Modify Current HOD Policy)

RESOLVED, that our American Medical Association amend H-185.929 Hearing Aid Coverage by addition as follows; and be it further

Hearing Aid Coverage H-185.929

1) Our American Medical Association supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2) Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3) Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4) Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5) Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6) Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7) Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.
8) Our AMA supports physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings.
9) Our AMA encourages the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia.

10) Our AMA advocates that hearing exams, hearing aids, cochlear implants, and aural rehabilitative services be covered in all Medicaid and CHIP programs and any new public payers. (Modify Current HOD Policy)

RESOLVED, that our AMA advocate that routine comprehensive vision exams and visual aids (including eyeglasses and contact lenses) be covered in all Medicaid and CHIP programs and by any new public payers (Directive to Take Action); and be it further

RESOLVED, that our AMA amend H-330.872, "Medicare Coverage for Dental Services" by addition and deletion as follows.

Medicare Coverage for Dental Services H-330.872
Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare, ~~and~~ Medicaid, CHIP, and other public payer beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease among ~~in the~~ Medicare, Medicaid, CHIP, and other public payer beneficiaries ~~population~~, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease ~~in the~~ among Medicare, Medicaid, CHIP, and other public payer beneficiaries ~~population~~, and the impact of expanded dental coverage on health care costs and utilization. (Modify Current HOD Policy)

Testimony on Resolution 102 was mixed. Although most speakers recognized the importance of providing hearing, dental, and vision services to Medicaid and CHIP enrollees, there was conflicting testimony about how the AMA should advocate for such coverage and whether it would be more effective for the AMA to work with state medical associations to increase Medicaid coverage. Potential unintentional consequences of covering and paying for hearing, vision, and dental services in all Medicaid and CHIP programs were also raised, including the Medicaid physician payment reductions and cuts to other important Medicaid services.

Your Reference Committee considered several proffered amendments but believes that additional study is needed to reconcile these amendments and address the complex issues raised in testimony. Accordingly, your Reference Committee recommends that Resolution 102 be referred.

(15) RESOLUTION 104 -- MEDICAID ESTATE RECOVERY REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 104 be referred.

HOD ACTION: Resolution 104 referred.

RESOLVED, that our American Medical Association oppose federal or state efforts to impose liens on or seek adjustment or recovery from the estate of individuals who received long-term services or supports coverage under Medicaid. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 104, including several calls for referral. Supportive testimony emphasized that few funds are recovered by Medicaid estate recovery efforts and that people with lower incomes are disproportionately affected. Your Reference committee did not hear significant support for alternate language that was proffered to support federal and state efforts to limit inequities in Medicaid estate recovery, including restriction of efforts to protect assets from recovery. Testimony in favor of referral highlighted the complexity of estate recovery efforts, the fact that states implement these programs differently, and the related issue of Medicaid spenddown rules. Your Reference Committee agrees and recommends that Resolution 104 be referred.

(16) RESOLUTION 113 -- SUPPORT PRESCRIPTION MEDICATION PRICE NEGOTIATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 113 be referred.

HOD ACTION: Resolution 113 referred.

RESOLVED, that our American Medical Association support pharmaceutical price negotiation for all prescription medications, both Medicare and private insurance (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for any medication price that is raised by a pharmaceutical company more than the rate of inflation be immediately subject to price negotiation in the following year's negotiation schedule (Directive to Take Action); and be it further

RESOLVED, that our AMA support extending the cap on annual out of pocket prescription drug spending in Medicare Part D plans to all insurance plans. (New HOD Policy)

Testimony on Resolution 113 was mixed. Supportive comments highlighted the need to rein in the high cost of prescription drugs while speakers opposing adoption raised concerns about unintended consequences of the Resolve clauses as written, including medications being removed from formularies and health plan premium increases. Testimony pointed out that private health plans already negotiate with manufacturers. Members of the Council on Medical Service and the Council on Legislation suggested reaffirmation of AMA policies addressing the high cost of prescription drugs, price negotiation for Medicare-provided medications, the use of arbitration in determining drug prices, and improved transparency including by pharmacy benefit managers (PBMs). Your Reference Committee heard several calls for referral and agrees that there are multiple

levels of complexity related to drug pricing across Medicare, Medicaid, and private plans.
Your Reference Committee recommends that Resolution 113 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(17) RESOLUTION 117 -- INSURANCE COVERAGE FOR GYNECOLOGIC ONCOLOGY CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 117 be referred for decision.

HOD ACTION: Resolution 117 referred for decision.

RESOLVED, that our American Medical Association support efforts to include gynecologic oncologists alongside other types of oncologists in network adequacy standards and requirements for public and private plans, including the Centers for Medicare & Medicaid Services standards.

Testimony on Resolution 117 was mixed. Some speakers wanted to promote gynecologic oncologists in network adequacy while others asked to broaden the scope of the resolution to include additional subspecialties. Testimony also focused on concerns about workforce shortages and highlighted that some counties, and even entire states, have no gynecologic oncologists to participate in a health plan network. Referral was suggested to address these concerns as well as the appropriateness of singling out a single specialty when other specialties may also want to be included in the AMA's network adequacy advocacy. Your Reference Committee agrees that additional work would be beneficial before new AMA policy is adopted but does not believe that a comprehensive study is needed. Accordingly, your Reference Committee recommends that Resolution 117 be referred for decision.

RECOMMENDED FOR NOT ADOPTION

(18) RESOLUTION 107 -- REQUIRING GOVERNMENT AGENCIES TO CONTRACT ONLY WITH NOT-FOR-PROFIT INSURANCE COMPANIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 107 be not adopted.

HOD ACTION: Resolution 107 not adopted.

RESOLVED, that our American Medical Association advocate that government-owned health agencies such as Medicare and Medicaid be required to contract only with not-for-profit insurance companies or cooperatives (Directive to Take Action); and be it further

RESOLVED, that our AMA support that those not-for-profit insurance companies or cooperatives receiving public revenues must allocate profits to reserves, investments in improving the quality of care in the system, or returned in the form of lower premiums for patients or the health agency. (New HOD Policy)

A preponderance of the testimony opposed adoption of Resolution 107. Speakers emphasized the lack of data on quality differences between nonprofit and for-profit insurers as well as uncertainties about how the Resolve clauses would impact the millions of people enrolled in for-profit health plans. Additional testimony highlighted complaints about nonprofit insurers and concerns that the resolution favors nonprofit insurers too much and could lead them to increase their market share and power. Although several speakers called for referral, your Reference Committee does not believe a study comparing for-profit and nonprofit insurers would lead to the development of impactful AMA policy and therefore recommends that Resolution 107 be not adopted.

(19) RESOLUTION 108 -- REQUIRING PAYMENT FOR PHYSICIAN SIGNATURES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 108 be not adopted.

HOD ACTION: Resolution 108 referred.

RESOLVED, that our American Medical Association advocate that insurance companies be required to pay a physician for any required physician signature and/or peer to peer review which is requested or required outside of a patient visit. (Directive to Take Action)

Testimony on Resolution 108 was mixed. Those who supported it introduced several amendments, including education related to new and existing CPT codes. The testimony

opposing Resolution 108 supported the goal of fairly remunerating physicians for work performed but questioned the feasibility of the resolution's ask, noting that the amount physicians might get paid for providing signatures will most likely not be enough to compensate them for the time it takes to advocate for such payment. As it may also increase patient burden for those with high deductible plans, the focus needs to be shifted to reducing the unreasonable demand for physician signatures. Testimony reiterated existing policy that prohibits the House of Delegates from directing the AMA to create new CPT codes. Additionally, the CPT nomenclature already includes codes to describe administrative tasks as well as medical consultative discussion and review. Therefore, your Reference Committee recommends that Resolution 108 be not adopted.

(20) RESOLUTION 114 -- BREAST CANCER SCREENING/CLINICAL BREAST EXAM COVERAGE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 114 be <u>not adopted</u>.

HOD ACTION: Resolution 114 <u>not adopted</u>.

RESOLVED, that our AMA advocate for Medicare coverage of clinical breast exams for all female and at-risk male patients during the Medicare Annual Wellness Visit (AWV) and Subsequent Annual Wellness Visit (SAWV) appointments. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 114. The testimony raised significant concerns suggesting that the benefit of clinical breast examinations is inconclusive. Several individuals and delegations cited an ACOG bulletin that references the U.S. Preventive Services Task Force (USPSTF) recommendation that there is insufficient evidence to recommend for or against clinical breast examination.

An individual and a delegation proffered language to the Resolve clause to amend the language to either "at-risk patients" or deleting "female and at-risk male" respectively, to make the resolution language more equitable. Another individual cited the need for access to clinical breast examinations. However, several other individuals and delegations reiterated that the information available from ACOG and USPSTF states that clinical breast exams are not recommended for average risk patients and that the AMA should not recommend policy related to Medicare coverage that is not evidence-based. Given the overwhelming testimony in opposition to the resolution, your Reference Committee recommends that Resolution 114 be not adopted.

Madam Speaker, this concludes the report of Reference Committee A . I would like to thank Rebekah Bernard, MD, Jared Buteau, Amish J. Dave, MD, MPH, Robert H. Emmick, Jr, MD, Richard A. Geline, MD, Adam I. Rubin, MD, and all those who testified before the Committee.

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Texas

Jared Buteau
South Carolina

Richard A. Geline, MD (Alternate)
Illinois

Amish J. Dave, MD, MPH (Alternate)
Washington

Adam I. Rubin, MD
American Academy of Dermatology Association

Debra Perina, MD
American College of Emergency Physicians
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-24)

Report of Reference Committee B

Peter Rheinstein, MD, JD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 11 — Safe and Effective Overdose Reversal Medications in Educational Settings
2. Board of Trustees Report 19 — Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication
3. Resolution 205 — Medical-Legal Partnerships & Legal Aid Services
4. Resolution 209 — Native American Voting Rights
5. Resolution 212 — Advocacy Education Towards a Sustainable Medical Care System
6. Resolution 221 — Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability
7. Resolution 223 — Increase in Children's Hospital Graduate Medical Education Funding
8. Resolution 227 — Medicare Reimbursement for Telemedicine
9. Resolution 228 — Waiver of Due Process Clauses
10. Resolution 230 — Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion
11. Resolution 231 — Supporting the Establishment of Rare Disease Advisory Councils
12. Resolution 232 — Medicare Advantage Part B Drug Coverage
13. Resolution 235 — Establish a Cyber-Security Relief Fund
14. Resolution 238 — AMA Supports Efforts to Fund Overdose Prevention Sites
15. Resolution 248 — Sustain Funding for HRSA (Health Resources Services and Administration) 340B Grant-Funded Programs
16. Resolution 250 — Endorsement of the Uniform Health-Care Decisions Act

RECOMMENDED FOR ADOPTION AS AMENDED

17. Board of Trustees Report 09 — Council on Legislation Sunset Review of 2014 House Policies
18. Board of Trustees Report 12 – AMA Efforts on Medicare Payment Reform
19. Board of Trustees Report 14 — Physician Assistant and Nurse Practitioner Movement Between Specialties

20. Board of Trustees Report 16 — Support for Mental Health Courts
21. Board of Trustees Report 17 — Drug Policy Reform
22. Board of Trustees Report 18 — Supporting Harm Reduction
23. Resolution 201 — Research Correcting Political Misinformation and Disinformation on Scope of Practice
24. Resolution 204 — Staffing Ratios in the Emergency Department
25. Resolution 206 — Indian Health Service Youth Regional Treatment Centers
26. Resolution 207 — Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse
27. Resolution 208 — Improving Supplemental Nutrition Programs
28. Resolution 214 – Support for Paid Sick Leave
29. Resolution 215 — American Indian and Alaska Native Language Revitalization and Elder Care
30. Resolution 216 — The AMA Supports H.R. 7225, the Bipartisan "Administrative Law Judges Competitive Service Restoration Act"
31. Resolution 219 — Bundling for Maternity Care Services
32. Resolution 220 — Restorative Justice for the Treatment of Substance Use Disorders
33. Resolution 222 — Studying Avenues for Parity in Mental Health & Substance Use Coverage
34. Resolution 224 — Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
35. Resolution 229 — Opposition to Legalization of Psilocybin
36. Resolution 233 — Prohibiting Mandatory White Bagging
37. Resolution 234 — State Prescription Drug Affordability Boards – Study
38. Resolution 239 — Requiring stores that sell tobacco products to display NYS Quitline information
39. Resolution 242 — Cancer Care in Indian Health Services Facilities
40. Resolution 247 — Prohibit Health Benefit Plans From Charging Cost Sharing for Covered Prostate Cancer Screening
41. Resolution 249 — Pediatric Specialty Medicaid Reimbursement
42. Resolution 252 – Model Legislation to Protect the Future of Medicine
43. Resolution 253 – Addressing the Failed Implementation of the No Surprises Act IDR Process

RECOMMENDED FOR ADOPTION IN LIEU OF

44. Board of Trustees Report 13 — Prohibiting Covenants Not-to-Compete
45. Resolution 210 — Support for Physicians Pursuing Collective Bargaining and Unionization
    Resolution 236 — Support of Physicians Pursuing Collective Bargaining and Unionization
46. Resolution 213 — Access to Covered Benefits with an Out of Network Ordering Physician
    Resolution 245 — Patient Access to Covered Benefits Ordered by Out-of-Network Physicians
47. Resolution 217 — Protecting Access to IVF Treatment
    Resolution 226 — Protecting Access to IVF Treatment
48. Resolution 251 — Streamline Payer Quality Metrics

RECOMMENDED FOR REFERRAL

49. Board of Trustees Report 15 — Augmented Intelligence Development, Deployment, and Use in Health Care
    Resolution 202 — Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims
    Resolution 246 — Augmented Intelligence in Health Care
50. Resolution 218 — Designation of Descendants of Enslaved Africans in America
51. Resolution 243 — Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes

RECOMMENDED FOR NOT ADOPTION

52. Resolution 225 — Humanitarian Efforts to Resettle Refugees

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

53. Resolution 237 — Encouraging the Passage of the Preventive Health Savings Act (S.114)
54. Resolution 244 — Graduate Medical Education Opportunities for American Indian and Alaska Native Communities

Amendments

If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 11 — SAFE AND EFFECTIVE OVERDOSE REVERSAL MEDICATIONS IN EDUCATIONAL SETTINGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 11 be adopted and that the remainder of the Report be filed.

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

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

1. Existing American Medical Association (AMA) policy entitled, "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications" (Policy H42 95.932), be reaffirmed, and (Reaffirm HOD Policy)
2. The third resolve of Policy H-95.908, "Increase Access to Safe and Effective Overdose Reversal Medications in Educational Settings" be rescinded and that the policy be updated as noted. (Modify Current HOD Policy)

1. Our AMA will encourage states, communities, and educational settings to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications readily accessible to staff and teachers to prevent opioid overdose deaths in educational settings.
2. Our AMA will encourage states, communities, and educational settings to remove barriers to students carrying safe and effective overdose reversal medications.
3. ~~Our AMA will study and report back on issues regarding student access to safe and effective overdose reversal medications.~~

Your Reference Committee heard supportive testimony for the recommendations of Board of Trustees Report 11. Your Reference Committee agrees that our AMA must continue efforts to support increased access to naloxone and other overdose reversal medications and reduce the stigma directed toward individuals who use drugs. Therefore, your Reference Committee recommends that Board of Trustees Report 11 be adopted, and that the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 19 — ATTORNEYS' RETENTION OF CONFIDENTIAL MEDICAL RECORDS AND CONTROLLED MEDICAL EXPERT'S TAX RETURNS AFTER CASE ADJUDICATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 19 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 19 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 240-A-23 and the remainder of this report be filed:

1. That our American Medical Association advocate that attorneys' discovery requests for the personal tax returns of a medical expert for the opposing party should usually be limited to 1099-MISC forms (miscellaneous income) (New HOD Policy); and

2. RESOLVED, That our AMA support through legislative or other relevant means the proper return or destruction of client medical records and medical expert's personal tax returns by attorneys within sixty days of the conclusion of the litigation (New HOD Policy).

Your Reference Committee heard supportive testimony on the recommendations of Board of Trustees Report 19. Your Reference Committee heard that seeking a medical expert's entire personal income tax returns is, in most instances, overly broad and unnecessarily invades the expert's privacy. Testimony supported limiting personal tax return discovery of a medical expert to miscellaneous income (1099-MISC forms), as it strikes a reasonable balance between allowing the probing for potential bias and protecting the expert's privacy and burdens. However, there was minimal testimony provided that noted that amendments should be made to the report to reflect that most contract EM physicians only receive a 1099 for all of their professional physician payments which would not adequately protect them from having to disclose the majority of their taxable income when testifying as an expert in a case. Your Reference Committee also heard that during litigation, certain documents that contain sensitive or confidential information, such as client medical records and tax returns, of medical experts are provided for the court and that there should be a reasonable timeframe after which such documents are destroyed. Therefore, your Reference Committee recommends that Board of Trustees Report 19 be adopted, and the remainder of the report be filed.

(3) RESOLUTION 205 — MEDICAL-LEGAL PARTNERSHIPS & LEGAL AID SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 205 be adopted.

HOD ACTION: Resolution 205 adopted.

RESOLVED, that our American Medical Association support the establishment and funding of medical-legal partnerships and civil legal aid services to meet patients' legal needs. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony for Resolution 205. Testimony indicated that Medical-Legal Partnerships (MLPs) had a proven track record of success in addressing issues concerning social determinates of health and advancing the goals of health equity. Testimony also noted numerous organizations, including the American Bar Association, that support the growth and effectiveness of Medical-Legal Partnerships. Very minimal testimony opposed the resolution noting a lack of understanding surrounding how these asks would be funded. In response to the testimony noting funding concerns additional testimony stated that this resolution was not intended to require our AMA to fund MLPs, and instead represented an opportunity for a collaboration between our AMA, the American Bar Association, and the Association of American Medical Colleges, as well as other interested organizations in advancing MLPs. Given the predominantly positive testimony, your Reference Committee recommends that Resolution 205 be adopted.

(4) RESOLUTION 209 — NATIVE AMERICAN VOTING RIGHTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 209 be adopted.

HOD ACTION: Resolution 209 adopted.

RESOLVED, that our American Medical Association support Indian Health Service, Tribal, and Urban Indian Health Programs becoming designated voter registration sites to promote nonpartisan civic engagement among the American Indian and Alaska Native population. (New HOD Policy)

Your Reference Committee heard testimony in support of Resolution 209. Your Reference Committee heard that it is important that our AMA support the designation of Indian Health Service, Tribal, and Urban Indian (ITU) Health Programs as official voter registration sites to promote nonpartisan civic engagement among American Indian and Alaska Native communities. Your Reference Committee further heard that civic engagement via voting can have a significant impact on social/structural determinants of health, and that this resolution is consistent with AMA policy that acknowledges that voting is a social

determinant of health. Testimony also stated that medical schools, teaching hospitals, and other federal agencies such as the Veterans Health Administration are recognized as designated voter registration sites, therefore, ITU health programs deserve the same designation to promote increased engagement in voting by Native peoples, especially given their close proximity to Native communities. Therefore, your Reference Committee recommends that Resolution 209 be adopted.

(5) RESOLUTION 212 — ADVOCACY EDUCATION TOWARDS A SUSTAINABLE MEDICAL CARE SYSTEM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 212 be adopted.

HOD ACTION: Resolution 212 adopted.

RESOLVED, that our American Medical Association explore innovative opportunities for engaging the public in advocacy on behalf of an improved healthcare environment. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony on Resolution 212. Your Reference Committee heard that AMA policy addresses the education of medical students and physicians on advocacy techniques and encourages their involvement in AMA advocacy efforts. Testimony also noted that our AMA believes that better-informed and more active citizens will result in better legislators, better government, and better health care. Your Reference Committee further heard that our AMA already has robust grassroots activities that include outreach to engage patient advocates through its Patient Advocate Network (PAN), and that PAN has been active on issues including Medicare, drug pricing, and prior authorization. Your Reference Committee also heard testimony that greater involvement of the public in AMA advocacy efforts potentially could make our AMA more effective in its advocacy on behalf of patients and the profession. Therefore, your Reference Committee recommends that Resolution 212 be adopted.

(6) RESOLUTION 221 — REFORMING MEDICARE PART B DRUG REIMBURSEMENT TO PROMOTE PATIENT AFFORDABILITY AND PHYSICIAN PRACTICE SUSTAINABILITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 221 be adopted.

HOD ACTION: Resolution 221 adopted.

RESOLVED, that our American Medical Association support the creation of a new reimbursement model for Part B drugs that 1) Disentangles reimbursement from the drug price, or any weighted market average of the drug price, by reimbursing physicians for the actual cost of the drug, and 2) Ensures adequate compensation for the cost of acquisition,

inventory, storage, and administration of clinically-administered drugs that is based on physician costs, not a percent of the drug price (New HOD Policy); and be it further

RESOLVED, that our AMA maintain the principles that any revised Part B reimbursement models should promote practice viability, especially for small physician practices, practices in rural and/or underserved areas, and practices with a significant proportion of Medicare patients, to promote continued treatment access for patients. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 221. Your Reference Committee heard that Resolution 221 addresses important needs for restructuring Medicare Part B drug reimbursement to better reflect the actual costs physicians incur in acquiring, storing, and administering drugs. Your Reference Committee heard that the resolution emphasizes ensuring adequate compensation for physicians, particularly focusing on the sustainability of small practices and those in rural or underserved areas. Therefore, your Reference Committee recommends that Resolution 221 be adopted.

(7) RESOLUTION 223 — INCREASE IN CHILDREN'S HOSPITAL GRADUATE MEDICAL EDUCATION FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 223 be adopted.

HOD ACTION: Resolution 223 adopted.

RESOLVED, that our American Medical Association collaborate with other relevant medical organizations to support and advocate for increased funding for the Children's Hospitals Graduate Medical Education program, recognizing the vital role it plays in shaping the future of pediatric healthcare in the United States. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 223. Your Reference Committee heard about how important consistent, and increased, funding is for Children's Hospital Graduate Medical Education (CHGME) programs as well as the important work undertaken by CHGME. Further testimony noted that CHGME is funded separately from other GME funding and receives considerably less funding than other GME programs leading to an inability to sustain growth in residency programs. Testimony also highlighted that our AMA has policy in line with this resolution and noted that our AMA has signed onto letters this year and last year asking for more CHGME funding, and consistently advocates for holistic funding increases for GME. Therefore, your Reference Committee recommends that Resolution 223 be adopted.

(8) RESOLUTION 227 — MEDICARE REIMBURSEMENT FOR TELEMEDICINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 227 be adopted.

HOD ACTION: Resolution 227 adopted.

RESOLVED, that our American Medical Association support removal of the December 31, 2024 "sunset" date currently set for Medicare to cease reimbursement for services provided via telemedicine, such that reimbursement of medical services provided by telemedicine be continued indefinitely into the future, consistent with what would be determined by the Relative Value Update Committee ("RUC"). (New HOD Policy)

Your Reference Committee heard strong supportive testimony on Resolution 227. Testimony reflected that a permanent telehealth solution is undebated at this juncture as it has provided vast improvement in access to care for both rural, urban, and underserved populations such as the environmental benefits due to decreased travel for medical appointments. An amendment was proposed to adopt more flexible telehealth reimbursement models, suggesting the need for adaptability in valuing these services. However, testimony also overwhelmingly noted that our AMA has been active in its advocacy efforts as part of the AMA Recovery Plan for America's Physicians and has consistently urged Congress to implement a permanent solution to supplant the flexibility granted by the public health emergency's waivers. Therefore, given the strong support and compelling benefits discussed, your Reference Committee recommends that Resolution 227 be adopted.

(9) RESOLUTION 228 — WAIVER OF DUE PROCESS CLAUSES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 228 be adopted.

HOD ACTION: Resolution 228 adopted as amended to read as follows:

RESOLVED, that our AMA will engage in advocacy for adoption of such legislation to eliminate waiver of due process clauses at the federal level.

RESOLVED, that our American Medical Association advocate that waiver of due process clauses be eliminated from all employment agreements between employed physicians and their non-physician employers, and be declared unenforceable in physicians' previously-executed employment agreements between physicians and their non-physician employers that currently exist (Directive to Take Action); and be it further

RESOLVED, that our AMA will engage in advocacy for adoption of such legislation at the federal level. (Directive to Take Action)

Your Reference Committee heard predominantly supportive testimony on Resolution 228. Testimony noted that most physicians are employed, and because they have little bargaining power with employers, cannot walk away from bad employment deals or negotiate due process clauses in employment or other contracts. Testimony also indicated that many states do not recognize medical staff bylaws as a contract so many physicians have no protections under hospital bylaws against due process waivers. Further testimony revealed that due process waivers harm patients because they discourage physicians from speaking out about patient care concerns and effectively make physicians at-will employees whose employment can be terminated at any time. Your Reference Committee notes that our AMA is already on the record supporting the 2024 "Physician and Patient Safety Act" as requested by the resolution. Therefore, your Reference Committee recommends that Resolution 228 be adopted.

(10) RESOLUTION 230 — PROTECTING PATIENTS FROM INAPPROPRIATE DENTIST AND DENTAL HYGIENIST SCOPE OF PRACTICE EXPANSION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 230 be adopted.

HOD ACTION: Resolution 230 adopted.

RESOLVED, that our American Medical Association advocacy efforts recognize the threat posed to patient safety when dentists and dental hygienists are authorized to practice medicine and administer procedures outside their level of education and training (New HOD Policy); and be it further

RESOLVED, that our AMA actively oppose regulatory and legislative efforts authorizing dentists and dental hygienists to practice outside their level of education and training. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 230. Testimony emphasized that patient safety is threatened when health care professionals, including dentists and dental hygienists, practice outside the scope of their education and training. Your Reference Committee heard that Resolution 230 aligns with our AMA's existing campaign supporting physician-led care and opposing inappropriate scope expansions. Therefore, your Reference Committee recommends that Resolution 230 be adopted.

(11) RESOLUTION 231 — SUPPORTING THE ESTABLISHMENT OF RARE DISEASE ADVISORY COUNCILS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 231 be adopted.

HOD ACTION: Resolution 231 referred.

RESOLVED, that our American Medical Association will support state legislation for the establishment of Rare Disease Advisory Councils in each state (New HOD Policy).

Your Reference Committee heard mixed testimony on Resolution 231. Your Reference Committee heard that Rare Disease Advisory Councils give the rare disease community a stronger voice in state government and support patients and their caregivers. Your Reference Committee heard that Rare Disease Advisory Councils are uniquely positioned to add gravitas to the needs of patients with rare diseases and the health care professionals that care for them. Additional testimony noted that Rare Disease Advisory Councils play an important role in filling gaps in knowledge surrounding this patient population and emphasized that it is important that these Councils are given the support they need to expand to all states (27 states already have these Councils), giving rare disease patients across the U.S. a strong and unified voice. However, your Reference Committee also heard testimony in support of referral. Testimony asked for further study on the involvement of specialists and medical specialty associations in Rare Disease Advisory Councils and expressed concern that Rare Disease Advisory Councils can become a mechanism for the pharmaceutical industry – rather than patients and their health care team – to further exert influence on the policymaking process. However, your Reference Committee heard mostly supportive testimony and also notes that adoption of Resolution 231 would not prevent our AMA from working with state and specialty associations to ensure the appropriate design of Rare Disease Advisory Councils. Therefore, your Reference Committee recommends that Resolution 231 be adopted.

(12) RESOLUTION 232 — MEDICARE ADVANTAGE PART B DRUG COVERAGE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 232 be adopted.

HOD ACTION: Resolution 232 adopted.

RESOLVED, that our American Medical Association will advocate with Congress, through the appropriate oversight committees, and with the Centers for Medicare & Medicaid Services (CMS) to require that Medicare Advantage (MA) plans cover physician-administered drugs and biologicals in such a way that the patient out of pocket cost is the same or less than the amount that a patient with traditional Medicare plus a Medigap plan would pay. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 232. Your Reference Committee heard that Resolution 232 addresses significant concerns regarding the equity of drug coverage in Medicare Advantage plans. Your Reference Committee heard that by supporting this resolution, our AMA would enhance its ability to advocate for more equitable drug coverage policies within these plans. Testimony noted that the disparities in out-of-pocket costs for drugs under Medicare Advantage plans lead to inequitable health outcomes, particularly for less affluent patients. Testimony highlighted that by advocating for changes to these plans, our AMA is effectively positioned to influence future Centers for Medicare & Medicaid Services rules. Though one individual testified that this increased coverage could lead to the erosion of Traditional Medicare plans, most of the testimony supported this resolution. Therefore, your Reference Committee recommends that Resolution 232 be adopted.

(13) RESOLUTION 235 — ESTABLISH A CYBER-SECURITY RELIEF FUND

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 235 be adopted.

HOD ACTION: Resolution 235 adopted.

RESOLVED, that our American Medical Association, through appropriate channels, advocate for a 'Cyber Security Relief Fund" to be established by Congress (Directive to Take Action); and be it further

RESOLVED, that the "Cyber Security Relief Fund" be funded through contributions from health insurance companies and all payers - as a mandated requirement by each of the payer (Directive to Take Action); and be it further

RESOLVED, that the "Cyber Security Relief Fund" only be utilized for 'uninterrupted' payments to all providers- in a structured way, in the event of future cyber-attacks affecting payments. (Directive to Take Action)

Your Reference Committee heard mixed but mostly supportive testimony on Resolution 235. Your Reference Committee heard about the importance of having a safety net to ensure that providers are paid by major insurers even if a cyber-attack should occur. Testimony also highlighted that cyber-attacks have continued to escalate and become more complex. Your Reference Committee heard that the recent ransomware attack on Change Healthcare caused thousands of physician payments to be withheld for weeks or months, resulting in devastating consequences to thousands of families because of inability to fulfill the payroll needs of the physicians and their employees. However, your Reference Committee also heard that this resolution should be referred for study so that this complex issue can be more thoroughly researched. Nevertheless, your Reference Committee heard significantly more positive testimony for this resolution than testimony in support of referral. Therefore, your Reference Committee recommends that Resolution 235 be adopted.

(14) RESOLUTION 238 — AMA SUPPORTS EFFORTS TO FUND OVERDOSE PREVENTION SITES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 238 be adopted.

HOD ACTION: Resolution 238 adopted.

RESOLVED, that our American Medical Association support legislation or regulation that would fund overdose prevention sites. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 238. Your Reference Committee heard about the benefits of overdose prevention sites (also known as safe injection sites or harm reduction centers) which include providing sterile supplies and administering naloxone in the event of an opioid-related overdose. Your Reference Committee heard testimony that overdose prevention sites have prevented thousands of deaths and have been successful in helping individuals access treatment for their substance use disorder. Your Reference Committee heard clear support for removing barriers to funding for these centers. Therefore, your Reference Committee recommends that Resolution 238 be adopted.

(15) RESOLUTION 248 — SUSTAIN FUNDING FOR HRSA (HEALTH RESOURCES SERVICES AND ADMINISTRATION) 340B GRANT-FUNDED PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 248 be adopted.

HOD ACTION: Resolution 248 referred for decision.

RESOLVED, that our American Medical Association amend Policy H-110.985 340B Drug Discount Program by addition as follows:

Our AMA: (1) will advocate for 340B Drug Discount Program (340B program) transparency, including an accounting of covered entities' 340B savings and the percentage of 340B savings used directly to care for underinsured patients and patients living on low-incomes; (2) will support recommendations to equip the Health Resources and Services Administration (HRSA) with more authority, resources and staff to conduct needed 340B program oversight; (3) recognizes the 340B program does not support the extent of care provided by ineligible physician practices to the medically indigent or underserved, and work with HRSA to establish 340B eligibility for all practices demonstrating a commitment to serving low-income and underserved patients; (4) will support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices; ~~and~~ (5) will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for

the 340B drug discount program.; and (6) supports 340B programs funded by HRSA grants in their utilization of the program as legislatively intended. (Modify Current HOD Policy)

Your Reference Committee heard minimal testimony on Resolution 248. Your Reference Committee heard supportive testimony from the authors of the resolution for the overall need for support of 340B programs. Your Reference Committee also heard testimony reflecting concerns about abuses of 340B programs and expressed that our AMA should not categorically support 340B programs because there are bad actors in this space. Therefore, your Reference Committee recommends that Resolution 248 be adopted.

(16) RESOLUTION 250 — ENDORSEMENT OF THE UNIFORM HEALTH-CARE DECISIONS ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 250 be adopted.

HOD ACTION: Resolution 250 referred.

RESOLVED, that our American Medical Association amend policy D-140.968, "Standardized Advance Directives," to read as follows:

Our AMA will endorse the "Uniform Health-Care Decisions Act," which was drafted and adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in 2023, and work with our state medical societies to advocate for its adoption in the states. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 250. Your Reference Committee heard that our AMA policy supported the 1993 Uniform Health-Care Decisions Act and that a new, updated Uniform Health Care Decisions Act was adopted in 2023 by the Uniform Laws Commission. Your Reference Committee heard that the new Act modernizes and expands the Act to reflect changes in how health care is delivered. Your Reference Committee also heard that this updated model legislation tackles complex issues that will impact medical practice, and that further study is needed as well as concerns around the separate advance directives specifically for mental health. However, your Reference Committee heard significantly more supportive testimony that highlighted all the work that our AMA has already done in this space. Therefore, your Reference Committee recommends that Resolution 250 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(17) BOARD OF TRUSTEES REPORT 09 — COUNCIL ON LEGISLATION SUNSET REVIEW OF 2014 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation of Board of Trustees Report 9 be amended by addition to read as follows:

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated, except for Policy 45.975, which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation of Board of Trustees Report 9 be adopted as amended and that the remainder of the report be filed.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Clause 3 of Policy H-185.951 be amended by addition and deletion to read as follows:

3. Our AMA will request a change in Centers for Medicare & Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on ~~his/her~~ their own to obtain and perform a protime/INR without restrictions.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Clause 1 of Policy H-355.975 be amended by addition and deletion to read as follows:

1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by ~~his/her~~ their state licensing agency should ~~his/her~~ their name appear on the National Practitioner Data Bank.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Clause 1 of Policy H-40.967 be amended by addition and deletion to read as follows:

1. Our AMA endorses voluntary physician participation in the military reserve components' medical programs as a means of actively aiding national defense while preserving the right of the individual physician to practice ~~his/her~~ their profession without interruption in peace time.

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

The Board of Trustees recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard testimony that Board of Trustees Report 9 should be adopted with two noted amendments. Your Reference Committee heard that some policies recommended to be retained were not updated to comply with AMA Policy H-65.942, which calls for gender-neutral language in AMA policy. Your Reference Committee agrees and therefore recommends that AMA Policies H-185.951, H-355.975, and H-40.967, which include the reference to “his” and “her,” be amended accordingly. Your Reference Committee heard additional testimony that H-45.975 includes policy that remains relevant regarding the substitution of third-class medical certificate with a driver's license. Your Reference Committee agrees and therefore recommends that H-45.975 should be retained.

(18) BOARD OF TRUSTEES REPORT 12 – AMA EFFORTS ON MEDICARE PAYMENT REFORM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 12 be amended by addition of the following Recommendations to read as follows:

1) Our AMA increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2) Our AMA step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3) Our AMA increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4) Our AMA advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 12 be adopted as amended and the remainder of the Report be filed.

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

Your Reference Committee heard testimony acknowledging and expressing appreciation for our AMA's strong advocacy activities outlined in BOT Report 12 to fix the broken Medicare physician payment system. Testimony emphasized, however, the need for increased dialogue and public communication about our AMA's ongoing advocacy for Medicare payment reform, a more effective use of social media platforms, and other public engagement strategies to mobilize broad public support and understanding of this pressing issue. Those testifying addressed the challenges physicians face due to inadequate reimbursement rates, a broken Medicare payment system, and highlighted the need for immediate reform to ensure the sustainability of medical practices across the nation. Your Reference Committee heard unanimous and passionate support for adding a recommendation to BOT Report 12 that would call for greater public attention to be generated that clearly articulates and bolsters the urgency of enacting Medicare payment reform. The recommendation calls on our AMA to increase media awareness, step up our AMA's public relations campaign, increase awareness to all physicians about the efforts of our AMA on Medicare payment reform, and advocate for abolition of all MIPS penalties. Your Reference Committees agrees with the unanimous sentiments of those testifying and recommends adding the proffered recommendation to BOT Report 12.

(19) BOARD OF TRUSTEES REPORT 14 — PHYSICIAN ASSISTANT AND NURSE PRACTITIONER MOVEMENT BETWEEN SPECIALTIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Recommendation of Board of Trustees Report 14 be amended by addition and deletion to read as follows:

3. That the AMA encourage hospitals and other health care entities employing nurse practitioners and physician assistants to ensure that the ~~nurse~~ practitioner's certification aligns with the specialty in which they will practice. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 14 be amended by addition of a fifth Recommendation to read as follows:

5. Our AMA continue to support research into the cost and quality of primary care delivered by nurse practitioners and physician assistants. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 14 be amended by addition of a sixth Recommendation to read as follows:

6. That our AMA continue to support research into the distribution and impact of nurse practitioners and physician assistants on primary care in underserved areas. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 14 be amended by addition of a seventh Recommendation to read as follows:

7. That our AMA continue to support expansion of access to physicians in under resourced areas. (New HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations one and two of Board of Trustees Report 14 referred.

HOD ACTION: Recommendations in Board of Trustees Report 14 adopted as amended and the remainder of the Report filed.

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

1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (New HOD Policy)
2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (New HOD Policy)
3. That the AMA encourage hospitals and other health care entities employing nurse practitioners to ensure that the nurse practitioner's certification aligns with the specialty in which they will practice. (New HOD Policy)
4. That the AMA continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching. (New HOD Policy)

Your Reference Committee heard supportive testimony for Board of Trustees Report 14. Your Reference Committee heard that while the concept of specialty switching by nurse practitioners and physician assistants is well known, there are little publicly available data on this issue. The Board Report, therefore, calls on our AMA to support research in this area to fill this knowledge gap, including through workforce surveys and studies, as well as research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. Your Reference Committee heard some testimony urging referral of Recommendations 1 and 2 of the Board of Trustees Report which call on our AMA to support such studies. However, your Reference Committee heard, on balance, testimony that favored adoption of all the Recommendations found in the Report instead of referral. Your Reference Committee also received an amendment, supported by others, that calls on our AMA to continue supporting research related to nurse practitioners practicing in primary care. This amendment is consistent with existing AMA policy and AMA's ongoing advocacy related to scope of practice. Therefore, Your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended, and the remainder of the report be filed.

(20) BOARD OF TRUSTEES REPORT 16 — SUPPORT FOR MENTAL HEALTH COURTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Recommendation of Board of Trustees Report 16 be amended by addition and deletion to read as follows:

(3) encourages diversion and treatment programs ~~drug courts to~~ that rely upon evidence-based models of care, including all medications used for ~~opioid~~ treatment of substance use disorder, for those who the judge or court determine would benefit from intervention, including treatment, rather than incarceration; and

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 16 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 16 adopted as amended and the remainder of the Report filed.

The Board of Trustees recommends that existing policy – Policy H-100.955, entitled, "Support for Drug Courts" – be amended by addition and deletion in lieu of Resolution 202 as follows:

Support for Diversion Programs, Including Drug Courts, Mental Health Courts, Veterans Courts, Sobriety Courts, and Similar Programs

Our AMA:

1. supports the establishment and use of diversion and treatment programs ~~drug courts~~, including drug courts, mental health courts, veterans courts, sobriety courts, and other types of similar programs, as an effective method of intervention within a comprehensive system of community-based supports and services for individuals with a mental illness or substance use disorder involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~;
2. encourages legislators and court systems to establish diversion and treatment programs ~~drug courts~~ at the state and local level in the United States; ~~and~~
3. encourages diversion and treatment programs ~~drug courts~~ to rely upon evidence-based models of care, including medications for opioid use disorder, for those who the judge or court determine would benefit from intervention, including treatment, rather than incarceration; and
4. supports individuals enrolled in diversion or treatment programs not be removed from a program solely because of evidence showing that an individual used illegal drugs while enrolled. (Modify HOD Policy)

Your Reference Committee heard supportive testimony for the recommendations of Board of Trustees Report 16. Your Reference Committee heard testimony that our current AMA policy and ongoing advocacy initiatives support increased access to evidence-based treatment for mental illness and substance use disorders. Testimony also encouraged support for access to medication for opioid use disorder and other substance use disorders. Your Reference Committee heard that if there are evidence-based programs for mental health and substance use disorders that can benefit individuals who would otherwise be incarcerated, those diversion programs should be strongly considered. Your Reference Committee received a minor technical amendment to this effect that was widely supported. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 16 be adopted as amended, and the remainder of the report be filed.

(21) BOARD OF TRUSTEES REPORT 17 — DRUG POLICY REFORM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Recommendation of Board of Trustees Report 17 amended by addition and deletion to read as follows:

~~1. That the American Medical Association (AMA) will continue to monitor the legal and public health effects of state and federal policies to reclassify criminal offenses for drug possession for personal use; (New HOD Policy)~~

1. That our American Medical Association (AMA) support elimination of criminal penalties for drug possession for personal use as part of a larger set of related public health and legal reforms designed to improve carefully selected outcomes.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Recommendation of Board of Trustees Report 17 be amended by addition to read as follows:

2. That the AMA will support federal and state efforts to automatically expunge, at no cost to the individual, criminal records for drug possession for personal use upon completion of a sentence or penalty; (New HOD Policy) and

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Recommendation in Boart of Trustees Report 17 be amended by addition to read as follows:

3. That the AMA support programs that provide comprehensive substance use disorder treatment and social support to people who use or possess illicit drugs for personal use as an alternative to incarceration-based penalties, including for persons under parole, probation, pre-trial, or other civic, criminal, or judicial supervision. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Board of Trustee Report 14 be amended by addition of a fourth Recommendation to read as follows:

4. Concurrently, that our AMA support robust policies and funding that facilitate people's access to evidence-based prevention, early intervention, treatment, harm reduction, and other supportive services – with an emphasis on youth and racially and ethnically minoritized people – based on individualized needs and with availability in all communities.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 17 be adopted as amended and the remainder of the Report be filed.

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

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 203 and the remainder of the report be filed:

1. That the American Medical Association (AMA) will continue to monitor the legal and public health effects of state and federal policies to reclassify criminal offenses for drug possession for personal use; (New HOD Policy)
2. That the AMA will support federal and state efforts to expunge, at no cost to the individual, criminal records for drug possession for personal use upon completion of a sentence or penalty; (New HOD Policy) and
3. That the AMA support programs that provide comprehensive substance use disorder treatment and social support to people who use or possess illicit drugs for personal use as an alternative to incarceration-based penalties for persons under parole, probation, pre-trial, or other civic, criminal, or judicial supervision. (New HOD Policy)

Your Reference Committee heard supportive testimony on the spirit of Board of Trustees Report 17. However, your Reference Committee heard limited testimony in support of continuing to monitor the effects of state and federal policies to decriminalize drug possession for personal use. Instead, most of the testimony heard by your Reference Committee called on our AMA to directly support decriminalization of drug possession for personal use as part of a larger set of public health and legal reforms. Your Reference Committee also heard wide-ranging concerns about racial and other inequities regarding Black and Brown individuals who are disproportionately incarcerated in the nation's jails and prisons for drug possession offenses. Testimony also highlighted that individuals who served a sentence or experienced other penalties for drug possession for personal use should have those penalties automatically expunged at the completion of their sentence. Your Reference Committee received amendments reflecting both concerns. Therefore, your Reference Committee recommends that Board of Trustees Report 17 be adopted as amended, and the remainder of the report be filed.

(22) BOARD OF TRUSTEES REPORT 18 — SUPPORTING HARM REDUCTION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation two of Board of Trustees Report 18be amended by addition and deletion to read as follows:

~~2.That the AMA oppose the concept, promotion, or practice of "safe smoking" with respect to inhalation of tobacco, cannabis or any illicit substance; (New HOD Policy)~~

2. That the AMA support decriminalization of harm reduction supplies that reduce the likelihood of injection drug use and mitigate health risks of all types of drug use, including injection drug use and smoking.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 18 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 18 adopted as amended and the remainder of the Report filed.

The Board of Trustees recommends that the following new policy be adopted in lieu of Resolution 204, and that the remainder of the report be filed.

1. That the American Medical Association (AMA) support efforts to decriminalize the possession of non-prescribed buprenorphine for personal use by individuals who lack access to a physician for the treatment of opioid use disorder; (New HOD Policy)

2. That the AMA oppose the concept, promotion, or practice of "safe smoking" with respect to inhalation of tobacco, cannabis or any illicit substance; (New HOD Policy)
3. That the AMA encourage additional study whether "safer smoking supplies" may be a potential harm reduction measure to reduce harms from the nation's overdose and death epidemic; and (New HOD Policy)
4. That the AMA reaffirm Policy D-95.987, "Prevention of Drug-Related Overdose." (Reaffirm AMA Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 18. Your Reference Committee heard supportive testimony on the benefits of increasing access to buprenorphine for the treatment of opioid use disorder (OUD) through multiple means, including support for decriminalizing non-prescribed buprenorphine for personal use. Your Reference Committee also heard significant testimony noting that there is no such thing as safe smoking. However, your Reference Committee also heard testimony noting support for access to harm reduction supplies that reduce the likelihood of injection drug use and mitigate the health risks of all types of drug use and received an amendment to this effect. Therefore, your Reference Committee recommends that Board of Trustees Report 18 be adopted as amended, and the remainder of the report be filed.

(23) RESOLUTION 201 — RESEARCH CORRECTING POLITICAL MISINFORMATION AND DISINFORMATION ON SCOPE OF PRACTICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 201 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA Board of Trustees report its findings and recommendations by the ~~I-24~~ A-25 meeting to the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings to the extent possible into our AMA's advocacy efforts on scope of practice. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 201 be adopted as amended.

HOD ACTION: Resolution 201 adopted as amended.

RESOLVED, that our American Medical Association perform a comprehensive literature review on current research on correcting political misinformation and disinformation and conduct field research on ways to correct political misinformation and disinformation amongst policymakers as it pertains to scope of practice (Directive to Take Action); and be it further

RESOLVED, that our AMA Board of Trustees report its findings and recommendations by the I-24 meeting to the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings to the extent possible into our AMA's advocacy efforts on scope of practice. (Directive to Take Action)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 201. There was consensus that our AMA's existing scope of practice campaign would benefit from targeted research on political misinformation and effective messaging in scope of practice advocacy. Your Reference Committee also heard that, to ensure there is enough time to pursue the research sought by this Resolution and prepare a report, the Board of Trustees report on the findings of this research should be due at the 2025 AMA Annual Meeting rather than the 2024 AMA Interim Meeting. Therefore, your Reference Committee recommends that Resolution 201 be adopted as amended.

(24) RESOLUTION 204 — STAFFING RATIOS IN THE EMERGENCY DEPARTMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 204 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners ~~NPPs~~ in the Emergency Department (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 204 be amended by addition and deletion to read as follows:

~~RESOLVED, that our AMA seek federal legislation or regulation that would require all Emergency Departments to be staffed 24-7 by a qualified physician. (Directive to Take Action)~~

RESOLVED, that our AMA support that all Emergency Departments be staffed 24-7 by a qualified physician. (New HOD policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 204 be adopted as amended.

HOD ACTION: Resolution 204 adopted as amended.

RESOLVED, that our American Medical Association seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper supervision of NPPs in the Emergency Department (Directive to Take Action); and be it further

RESOLVED, that our AMA seek federal legislation or regulation that would require all Emergency Departments to be staffed 24-7 by a qualified physician. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 204. Your Reference Committee heard significant testimony in support of federal law prohibiting staffing ratios that do not allow for proper supervision of non-physicians in the emergency department; this included an amendment to clarify that such supervision must be done by a physician. Regarding the second Resolved clause, your Reference Committee heard testimony opposing the independent practice of non-physicians and promoting physician-led, team-based, care in the emergency department. While some testimony indicated that there is no shortage of emergency medicine physicians and that it would not be a hardship on the profession to ensure that a physician was onsite to ensure proper supervision of emergency care services, other testimony indicated that a 24/7 physician supervision requirement would be impossible for some rural and underserved hospitals and could lead to hospital closures. Your Reference Committee also heard significant testimony noting that a Board of Trustees report is currently being drafted for the AMA 2024 Interim Meeting and that this report will directly address the issue of possible rural exceptions to requirements for 24/7 physician supervision in emergency departments. Your Reference Committee understands that this pending Board report will be influential in the development of AMA policy when it comes to physician supervision in emergency departments. Therefore, your Reference Committee recommends that the first Resolved clause be adopted as amended and the second Resolved clause be referred.

(25) RESOLUTION 206 — INDIAN HEALTH SERVICE YOUTH REGIONAL TREATMENT CENTERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 206 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support the expansion of Indian Health Service Youth Regional Treatment Centers, recognizing them as ~~a model for~~ culturally-rooted, ~~evidence-based~~ behavioral health and substance use disorder treatment centers for~~, and prompt referral of eligible~~ American Indian/Alaskan Native (AI/AN) youth t~~o Youth Regional Treatment Centers (YRTCs) for community-directed care~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 206 be adopted as amended.

HOD ACTION: Resolution 206 adopted as amended.

RESOLVED, that our American Medical Association support the expansion of Indian Health Service Youth Regional Treatment Centers, recognizing them as a model for culturally-rooted, evidence-based behavioral health treatment, and prompt referral of eligible AI/AN youth to Youth Regional Treatment Centers (YRTCs) for community-directed care. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 206. Your Reference Committee heard that American Indian/Alaskan Native (AI/AN) populations benefit from culturally rooted care for mental illness and substance use disorders. Testimony also stated that the AI/AN population would benefit from greater access to evidence-based care for mental illness and substance use disorders. Your Reference Committee also heard testimony concerning whether the programs supported by the Indian Health Service all are "models," and received multiple amendments suggesting the removal of this language in the resolution, but heard nothing to suggest any hesitation surrounding supporting the treatment programs in general. Therefore, your Reference Committee recommends that Resolution 206 be adopted as amended.

(26) RESOLUTION 207 — BIOSIMILAR USE RATES AND PREVENTION OF PHARMACY BENEFIT MANAGER ABUSE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 207 be deleted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 207 be adopted as amended.

HOD ACTION: A new Resolve added to Resolution 207 to read as follows:

RESOLVED, that our AMA supports coverage structures that: increase use of lower cost biosimilars when clinically appropriate, share savings between payers and patients ~~physicians~~, and reduce patient costs.

HOD ACTION: The new Resolve of Resolution 207 referred.

HOD ACTION: Resolution 207 adopted as amended.

RESOLVED, that our American Medical Association support economic incentives to increase physician use of less expensive biosimilars instead of their reference biologics (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 207. Your Reference Committee heard support for the concept of decreasing patient cost by prescribing less expensive medication and ensuring fair competition for biosimilars. However, your Reference Committee also heard that financial compensation for physicians should not be a factor in what physicians ultimately prescribe, rather the patient's health should be the only determining factor. Further testimony suggested that removing the reference to economic incentives would strengthen the resolution. Therefore, your Reference Committee recommends that Resolution 207 be adopted as amended.

(27) RESOLUTION 208 — IMPROVING SUPPLEMENTAL NUTRITION PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association supports ~~regulatory and legal reforms to~~ extending ~~multie~~ligibility for USDA Food Assistance to enrolled members of federally-recognized American Indian and Alaska Native Tribes and Villages to ~~all~~ federal feeding programs~~, such as, but not limited to, Supplemental Nutrition Assistance Program (SNAP) and Food Distribution Program on Indian Reservations (FDPIR)~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 208 be adopted as amended.

HOD ACTION: Resolution 208 adopted as amended.

RESOLVED, that our American Medical Association support regulatory and legal reforms to extend multieligibility for USDA Food Assistance to enrolled members of federally-

recognized American Indian and Alaska Native Tribes and Villages to all federal feeding programs, such as, but not limited to, Supplemental Nutrition Assistance Program (SNAP) and Food Distribution Program on Indian Reservations (FDPIR). (New HOD Policy)

Your Reference Committee heard testimony in favor of Resolution 208. Your Reference Committee heard that food insecurity is a public health crisis, especially among American Indian and Alaska Native (AI/AN) persons, and that such individuals experience food insecurity at twice the rate of their white counterparts. Your Reference Committee further heard that US nutrition programs for AI/AN persons, including the Food Distribution Program on Indian Reservations (FDPIR) and the recently launched Indian Health Service (IHS) Produce Prescription Pilot Program, differ from other nutrition programs because they include staple foods and ingredients commonly used in pre-contact AI/AN societies and food systems. Moreover, your Reference Committee heard that federally recognized AI/AN Tribes and Villages without a reservation or land base, and the 2.8 million AI/AN persons in urban areas (greater than the population on Tribal lands), are all ineligible for federal nutrition assistance programs for AI/AN persons. However, your Reference Committee heard that amendments to the resolution would help clarify its intent and implementation. Specifically, your Reference Committee heard that the language in the resolution, referring to “multieligibility” for all United States Department of Agriculture food programs, is not clear and that amended language is needed to make the resolution’s intent and its implementation stronger. Therefore, your Reference Committee recommends that Resolution 208 be adopted as amended.

(28) RESOLUTION 214 — SUPPORT FOR PAID SICK LEAVE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 214 be amended by addition to read as follows:

RESOLVED, that our American Medical Association amend Policy H-440.823, "Paid Sick Leave," as follows:

Paid Sick Leave H-440.823

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; ~~and~~ (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome; and (4) advocates for federal and state policies that guarantee employee access to protected paid sick leave without unduly burdening small businesses. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 214 be adopted as amended.

HOD ACTION: Resolution 214 adopted as amended.

RESOLVED, that our American Medical Association amend Policy H-440.823, "Paid Sick Leave," as follows:

Paid Sick Leave H-440.823

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; ~~and~~ (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome; and (4) advocates for federal and state policies that guarantee employee access to protected paid sick leave. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 214. Your Reference Committee heard that paid leave is a matter of public health and that it is necessary for patients to have reasonable periods of leave to care for themselves and immediate family members. Testimony also noted that that more than half of the lowest-paid workers cannot get time off for an illness. However, your Reference Committee also heard that it can be

extremely difficult for small physician practices, and small businesses in general, to provide paid sick leave for their employees. Therefore, your Reference Committee recommends that Resolution 214 be adopted as amended.

(29) RESOLUTION 215 — AMERICAN INDIAN AND ALASKA NATIVE LANGUAGE REVITALIZATION AND ELDER CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 215 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association recognize that access to language concordant services for American Indian and Alaka Native (AI/AN) patients will require ~~targeted~~ investment ~~as~~in Indigenous languages in North America ~~are threatened due to a complex history of removal and assimilation by state and federal actors~~ (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 215 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~collaborate with stakeholders, including but not limited to the National Indian Council on Aging and Association of American Indian Physicians, to identify~~ support the development of best practices for AI/AN elder care to ensure this group is provided culturally-competent healthcare outside of the umbrella of the Indian Health Service. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 215 be adopted as amended.

HOD ACTION: Resolution 215 adopted as amended.

RESOLVED, that our American Medical Association recognize that access to language concordant services for AI/AN patients will require targeted investment as Indigenous languages in North America are threatened due to a complex history of removal and assimilation by state and federal actors (New HOD Policy); and be it further

RESOLVED, that our AMA support federal-tribal funding opportunities for American Indian and Alaska Native language revitalization efforts, especially those that increase health

information resources and access to language-concordant health care services for American Indian and Alaska Native elders living on or near tribal lands (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with stakeholders, including but not limited to the National Indian Council on Aging and Association of American Indian Physicians, to identify best practices for AI/AN elder care to ensure this group is provided culturally-competent healthcare outside of the umbrella of the Indian Health Service. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony on Resolution 215. Your Reference Committee heard that the population of American Indian/Alaska Native (AI/AN) elders are the stewards of hundreds of Indigenous cultures, languages, and traditional knowledge systems. Your Reference Committee further heard that AI/AN elders experience significant health and socioeconomic inequities including the lowest life expectancy of all racial/ethnic groups in the U.S. and a high uninsurance rate. Moreover, your Reference Committee heard that while AI/AN elders receive primary care through the Indian Health Service (IHS), underfunding and understaffing has forced IHS to rely on non-IHS facilities for more specialized elder care, including hospice and respite care, which necessitates AI/AN elders having to navigate unknown health systems not respectful of their cultural values and traditions. Your Reference Committee further heard that culturally competent care is vital for health outcomes and is even more critical for older adults with changes in cognition due to delirium and dementia. Furthermore, your Reference Committee heard that our AMA has long-standing policy that supports improving health care for American Indians, both those living on reservations and outside reservation lands, in order to decrease health inequities for these individuals. Additional testimony in support noted that amendments would help clean up some language in the resolution to make it less controversial and allow for more flexibility in implementing its intent. Your Reference Committee appreciates the importance of the issues identified in this resolution and agrees that amendments would be helpful. Therefore, your Reference Committee recommends that Resolution 215 be adopted as amended.

(30) RESOLUTION 216 — THE AMA SUPPORTS H.R. 7225, THE BIPARTISAN "ADMINISTRATIVE LAW JUDGES COMPETITIVE SERVICE RESTORATION ACT"

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~support H.R. 7225, the bipartisan "Administrative Law Judges Competitive Service Restoration Act" that~~ supports ~~the~~ merit-based processes for the selection of all Medicare/Medicaid Administrative Law Judges. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 216 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 216 be changed to read as follows:

MERIT-BASED SELECTION OF ADMINISTRATIVE LAW JUDGES

HOD ACTION: Resolution 216 adopted as amended with a change of title.

MERIT-BASED SELECTION OF ADMINISTRATIVE LAW JUDGES

RESOLVED, that our American Medical Association support H.R. 7225, the bipartisan "Administrative Law Judges Competitive Service Restoration Act" that supports the merit-based process for the selection of all Medicare/Medicaid Administrative Law Judges. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 216. Your Reference Committee heard that the selection process for Administrative Law Judges (ALJs) is important for ensuring impartial and competent adjudication in Medicare and Medicaid disputes. Your Reference Committee also heard that current regulations significantly impact the quality of decisions made by ALJs and that a merit-based selection process is important to maintain high standards. However, your Reference Committee heard that referencing a specific bill in our policy is not consistent with our AMA's standard practice. Testimony noted that our AMA avoids using specific bill numbers in policy to maintain flexibility and avoid endorsing particular legislative texts that may change over

time. An amendment was provided that removed the specific legislation included in the Resolution. Therefore, your Reference Committee recommends that Resolution 216 should be adopted as amended with a change in title.

(31) RESOLUTION 219 — BUNDLING FOR MATERNITY CARE SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~advocates for~~ supports the separate payment of services not accounted for in the valuation of the maternity global codes and opposes the inappropriate bundling of related services. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 219 be adopted as amended.

HOD ACTION: Resolution 219 adopted as amended.

RESOLVED, that our American Medical Association advocates for the separate payment of services not accounted for in the valuation of the maternity global codes and opposes the inappropriate bundling of related services. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 219. Your Reference Committee heard that better recognition and reimbursement for comprehensive maternity care that extends beyond what is covered by the global obstetric codes is needed. Testimony highlighted that many critical services provided during pregnancy, such as increased screenings, intensive counseling for genetic tests, group prenatal care, social assessment and management of social determinants of health, and the management of labor to avoid cesarean sections are not adequately accounted for in the current coding system. Your Reference Committee also heard that our AMA is actively engaging in a comprehensive review of maternity care practices through a Current Procedural Terminology (CPT) workgroup, which is expected to propose significant changes to the existing coding system to better reflect current medical practices and address stakeholder needs. A minor amendment was also offered on this resolution. Testimony noted that this minor amendment was needed to align with how the CPT process works. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended.

(32) RESOLUTION 220 — RESTORATIVE JUSTICE FOR THE TREATMENT OF SUBSTANCE USE DISORDERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 220 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association (1) continues to support the right of incarcerated individuals to receive appropriate care for substance use disorders, (2) supports efforts ~~providing incentives~~ for incarcerated individuals to participate ~~overcome substance use disorders, such as participation~~ in a treatment or diversion program ~~as a condition for early release~~, and (3) supports providing access to social services and family therapy during and after incarceration (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 220 be amended by addition to read as follows:

RESOLVED, that our AMA (1) recognizes that criminalization of substance use disproportionately impacts minoritized and disadvantaged communities due to structural racism and implicit bias, (2) acknowledges inequitable sentencing structures, such as towards crack cocaine versus opioids, have contributed to unjust imprisonments, and (3) supports stigma reduction, implicit bias and antiracism training for medical professionals working in correctional facilities. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 220 be adopted as amended.

HOD ACTION: Resolution 220 adopted as amended.

RESOLVED, that our American Medical Association (1) continues to support the right of incarcerated individuals to receive appropriate care for substance use disorders, (2) supports providing incentives for incarcerated individuals to overcome substance use disorders, such as participation in treatment as a condition for early release, and (3) supports providing access to social services and family therapy during and after incarceration (New HOD Policy); and be it further

RESOLVED, that our AMA (1) recognizes that criminalization of substance use disproportionately impacts minoritized and disadvantaged communities due to structural racism and implicit bias, (2) acknowledges inequitable sentencing structures, such as towards crack cocaine versus opioids, have contributed to unjust imprisonments, and (3) supports implicit bias and antiracism training for medical professionals working in correctional facilities. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony on Resolution 220. Your Reference Committee heard about the benefits of evidence-based treatment for substance use disorders while in jail or prison. Testimony also highlighted inequitable treatment for racially and ethnically diverse populations while incarcerated. However, your Reference Committee heard concerns about coercing individuals into treatment while also hearing testimony that jails and prisons are sub-optimal places to receive treatment for a substance use disorder. Your Reference Committee appreciates the input from our colleagues in the U.S. Public Health Service in supporting access to evidence-based care for substance use disorders. Your Reference Committee agrees with both points. Therefore, your Reference Committee recommends that Resolution 220 be adopted as amended.

(33) RESOLUTION 222 — STUDYING AVENUES FOR PARITY IN MENTAL HEALTH & SUBSTANCE USE COVERAGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 222 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association increase advocacy efforts towards the National Association of Insurance Commissioners (NAIC) and state and federal policymakers~~continue to advocate~~ for meaningful financial and other ~~study potential~~ penalties ~~to~~for insurers that do ~~for~~ not comply~~ing~~ with mental health and substance use parity laws~~.~~;and be it further (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 222 be adopted as amended.

HOD ACTION: A second Resolve added to Resolution 222 to read as follows:

RESOLVED, that our American Medical Association work with state medical societies to advocate to state departments of insurance for meaningful enforcement of penalties for insurers that do not comply with mental health and substance use parity laws.

HOD ACTION: Resolution 222 adopted as amended.

RESOLVED, that our American Medical Association study potential penalties to insurers for not complying with mental health and substance use parity laws. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 222. Your Reference Committee heard testimony expressing deep frustration that mental health and substance use disorder parity laws are not meaningfully enforced despite more than a decade of parity violations by health insurance companies. Your Reference Committee also heard testimony that even when parity laws are enforced, the penalties are too small and ineffectual to prevent future violations. Your Reference Committee heard testimony that our AMA's state and federal advocacy has called for meaningful penalties to be imposed against health insurers and other payers that violate mental health substance use disorder parity laws. Testimony noted that while there could be benefits from an additional study of gaps in enforcement and potential penalties, there is greater benefit to our AMA focusing its resources on continued advocacy, and received an amendment expressing this. Therefore, your Reference Committee recommends that Resolution 222 be adopted as amended.

(34) RESOLUTION 224 — ANTIDISCRIMINATION PROTECTIONS FOR LGBTQ+ YOUTH IN FOSTER CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 224 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~collaborate with state medical societies and other appropriate stakeholders to~~ supports policies on the federal and state levels that establish nondiscrimination protections within the foster care system on the basis of sexual orientation and gender identity (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 224 be deleted.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 224 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~encourage~~ supports child welfare agency~~ies~~ ~~to implement~~ practices, policies, and regulations that: (a) provide training to child welfare professionals, social workers, and foster caregivers on how to establish safe, stable, and affirming care placements for LGBTQ+ youth; (b) ~~adopt programs to~~ prevent and reduce violence against LGBTQ+ youth in foster care; (c) improve recruitment of foster families that are affirming of LGBTQ+ youth; and (d) allow gender diverse youth to be placed in residential foster homes that are willing to accept their gender identity. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 224 be adopted as amended.

HOD ACTION: The second Resolve of Resolution 224 referred.

HOD ACTION: Resolution 224 adopted as amended.

RESOLVED, that our American Medical Association collaborate with state medical societies and other appropriate stakeholders to support policies on the federal and state levels that establish nondiscrimination protections within the foster care system on the basis of sexual orientation and gender identity (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Foster Care Analysis and Reporting System only when strong privacy protections exist (New HOD Policy); and be it further

RESOLVED, that our AMA encourage child welfare agencies to implement practices, policies, and regulations that: (a) provide training to child welfare professionals, social workers, and foster caregivers on how to establish safe, stable, and affirming care placements for LGBTQ+ youth; (b) adopt programs to prevent and reduce violence against LGBTQ+ youth in foster care; (c) improve recruitment of foster families that are affirming

of LGBTQ+ youth; and (d) allow gender diverse youth to be placed in residential foster homes that are willing to accept their gender identity. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 224. Your Reference Committee heard that this was a timely issue and emphasized the unique vulnerability of LGBTQ+ youth in foster care. However, your Reference Committee also heard that this resolution would support the collection of sexual orientation data by the Adoption and Foster Care Analysis and Reporting System (AFCARS). Testimony highlighted that the collection of sexual orientation data by AFCARS was proposed by the federal government back in 2016, however, this portion of the proposed rule was never implemented and in 2020 was ultimately rejected. Your Reference Committee heard that since then, there has been a divide in the community concerning whether these data should be collected. Testimony noted that most LGBTQ+ groups believe that this information should be collected by the federal government to enhance recruitment of foster homes, promote visibility for marginalized groups, help to analyze youth outcomes, and address disparities. However, your Reference Committee also heard that many state and local child welfare agencies believe that AFCARS is not the appropriate vehicle to collect this information, that it was unclear how this information in a Federal Government database would result in support services for children, and that this information should be tracked separately from AFCARS. Further, testimony noted that state and local child welfare agencies track information about a youth's or provider's sexual orientation and noted that this information can be collected as part of the title IV-E agency's casework and should be documented in the case file. Additional testimony, though supportive of the concepts in the resolution, noted concern that the resolution could out a child’s gender identity/sexual orientation in the foster process before the child is ready, causing harm to the child. Your Reference Committee heard that due to this divide in the community, our AMA should not adopt the second resolved since our AMA does not have a fully informed position on this topic. Your Reference Committee also heard that the first and third resolves should be slightly amended to broaden them so that they are more applicable across all the work that our AMA does. Your Reference Committee also notes a grammatical error in the third resolved. Therefore, your Reference Committee recommends that Resolution 224 be adopted as amended.

(35) RESOLUTION 229 — OPPOSITION TO LEGALIZATION OF PSILOCYBIN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association oppose any legislative efforts ~~relatable~~ related to legalization of Psilocybin/Psilocin or its related substances use, except those which have received FDA approval or those prescribed in the context of approved investigational studies. (New HOD Policy) and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 229 be amended by addition of a second Resolve clause to read as follows:

RESOLVED, that our AMA support decriminalization of possession of psychedelics, entactogens, or related substances for personal use.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 229 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that that the title of Resolution 229 be changed to read as follows:

PSILOCYBIN AND PSYCHEDELICS

HOD ACTION: Resolution 229 adopted as amended with a change of title.

PSILOCYBIN AND PSYCHEDELICS

RESOLVED, that our American Medical Association oppose any legislative efforts relatable to legalization of Psilocybin/Psilocin or its related substances use. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 229. Your Reference Committee heard clear support for the Food and Drug Administration (FDA) approval process and investigational clinical trials to identify whether new treatments would be efficacious for patients. Your Reference Committee heard concerns that some drugs have been legalized or otherwise supported through the state legislative process rather than evidence-based approaches. Your Reference Committee also heard opposition to the original resolution from multiple delegations noting that comprehensive opposition to the legalization of psylocibin was too broad of a stance for our AMA—particularly given that there is some evidence of potential positive benefits of some uses of psilocybin to treat certain conditions. Testimony supporting referral was limited. Your Reference Committee heard no opposition to the amendment calling for decriminalization of possession of psychedelics, entactogens, or related substances for personal use. Therefore, your Reference Committee recommends that Resolution 229 be adopted as amended.

(36) RESOLUTION 233 — PROHIBITING MANDATORY WHITE BAGGING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 233 be amended by addition to read as follows:

RESOLVED, that our American Medical Association urge state and federal policymakers to enact legislation to prohibit the mandatory use of white bagging policies that condition coverage of a clinician-administered drug, such as an IV infusion, on the drug being dispensed from a pharmacy benefit manager-affiliated mail order pharmacy. (Directive to Take Action).

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 233 be adopted as amended.

HOD ACTION: Resolution 233 adopted as amended.

RESOLVED, that our American Medical Association urge state and federal policymakers to enact legislation to prohibit the mandatory use of white bagging (Directive to Take Action).

Your Reference Committee heard supportive testimony on Resolution 233. Your Reference Committee heard that the practice of “white bagging” when mandatory, excludes payment for medically necessary drugs from any physician that is not under common ownership with the insurer or Pharmacy Benefits Managers (PBMs). Your Reference Committee also heard testimony that emphasized the potential negative outcomes from this practice including the severe risk of limiting access, disruptions of care, and drug waste. Your Reference Committee also heard testimony that noted the importance of defining white bagging more definitively and received amendments to this

effect which received support. Therefore, Your Reference Committee recommends that Resolution 233 be adopted as amended.

(37) RESOLUTION 234 — STATE PRESCRIPTION DRUG AFFORDABILITY BOARDS - STUDY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 234 be deleted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 234 be adopted as amended.

HOD ACTION: Resolution 234 adopted as amended.

RESOLVED, that our American Medical Association conduct a study to determine how upper payment limits (UPLs) established by state prescription drug affordability boards (PDABs) will impact reimbursement for physician-administered drugs and what impact state UPLs will have on patient access to care (Directive to Take Action); and be it further

RESOLVED, that our AMA report the results of the study on UPLs to the House of Delegates at A-25. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony on Resolution 234. Your Reference Committee heard support for our AMA to conduct an economic impact study of state prescription drug affordability boards on physician practices and patients' access to treatment. Your Reference Committee appreciates the offer from the resolution's author to contribute to that study. Your Reference Committee also heard that the proposed requirement in this resolution to report the study's results to the House of Delegates at A-25, is redundant because our AMA already has established mechanisms for reporting such studies. Therefore, your Reference Committee recommends that Resolution 234 be adopted as amended.

(38) RESOLUTION 239 — REQUIRING STORES THAT SELL TOBACCO PRODUCTS TO DISPLAY NYS QUITLINE INFORMATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 239 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association seek federal legislation and/or regulation requiring all stores licensed to sell tobacco or nicotine products to display easily visible information about the ~~CDC hotline~~ national tobacco cessation quitline portals and telephone hotlines ~~1-800-QUIT-NOW~~, in multiple languages and/or the corresponding information for a given ~~the corresponding~~ state or territory. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 239 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 239 be changed to read as follows:

REQUIRING STORES THAT SELL TOBACCO PRODUCTS TO DISPLAY THE NATIONAL TOLLFREE QUIT NOW HOTLINE.

HOD ACTION: Resolution 239 adopted as amended with a change of title.

REQUIRING STORES THAT SELL TOBACCO PRODUCTS TO DISPLAY THE NATIONAL TOLLFREE QUIT NOW HOTLINE.

RESVOLVED, that our American Medical Association seek federal legislation and/or regulation requiring all stores licensed to sell tobacco or nicotine products to display easily visible information about the CDC hotline 1-800-QUIT-NOW in multiple languages and/or the information for the corresponding state or territory. (Directive to Take Action)

Your Reference Committee heard limited testimony in support of Resolution 239. Your Reference Committee heard that some states' Tobacco Control Programs allow tobacco products to contain a Quitline phone number and website on them. Your Reference

Committee also heard that our AMA takes a strong stand against smoking and favors aggressively pursuing all avenues of educating the public on the hazards of using tobacco products and the continuing high costs of this serious but preventable problem. Moreover, your Reference Committee heard that, in light of the continuing and urgent need to assist individuals in smoking cessation, our AMA policy states that physicians should assume a leadership role in establishing national policy on this topic and assume the primary task of educating the public and their patients about the danger of tobacco use (especially cigarette smoking). Your Reference Committee further heard that our AMA also strongly supports federal and state efforts related to tobacco cessation and has policy supporting the use of the federally funded CDC National Tobacco Quitline network and ongoing media campaigns to help Americans quit using tobacco. Your Reference Committee also heard that adopting Resolution 239 would be consistent with existing AMA policy but that amendments were needed to change the title to remove the reference to New York State's Quitline, to add a reference to national portals and hotlines, and to make implementation of the resolution less costly and easier to implement. Therefore, your Reference Committee recommends that Resolution 239 be adopted as amended with a change in title.

(39) RESOLUTION 242 — CANCER CARE IN INDIAN HEALTH SERVICES FACILITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 242 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~actively advocate~~ support ~~for~~ the federal government continuing to ~~continue~~ enhanc~~e~~ing and develop~~ing~~ alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health ~~cancer~~ care, including ~~and cancer-directed therapies~~ within and outside of the established Indian Health Service (IHS) system (New HOD Policy)~~(Directive to Take Action)~~; and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 242 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA (a) support collaborative research efforts to better understand the limitations of IHS health ~~cancer~~ care, including barriers to access, disparities in treatment outcomes, and areas for improvement and (b) encourage ~~cancer linkage~~ studies between the IHS and the CDC to better evaluate regional ~~cancer rates,~~ health outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations, including with respect to cancer care. (New HOD Policy)~~(Directive to Take Action)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 242 be amended by addition of a third Resolve clause to read as follows:

RESOLVED, That our AMA support federal and other efforts to increase funding for and provide technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities, including by contracting with other physician practices. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 242 be adopted as amended.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title of Resolution 242 be changed to read as follows:

HEALTH CARE ACCESS FOR AMERICAN INDIANS AND ALASKA NATIVES

HOD ACTION: Resolution 242 adopted as amended with a change of title.

HEALTH CARE ACCESS FOR AMERICAN INDIANS AND ALASKA NATIVES

RESOLVED, that our American Medical Association actively advocate for the federal government to continue enhancing and developing alternative pathways for American Indian and Alaska Native patients to access the full spectrum of cancer care and cancer-directed therapies outside of the established Indian Health Service system (Directive to Take Action); and be it further

RESOLVED, that our AMA (a) support collaborative research efforts to better understand the limitations of IHS cancer care, including barriers to access, disparities in treatment outcomes, and areas for improvement and (b) encourage cancer linkage studies between the IHS and the CDC to better evaluate regional cancer rates, outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 242. Your Reference Committee heard that it is imperative for our AMA to support increasing access to cancer care in Indian Health Service facilities because cancer is the leading cause of death among American Indian and Alaska Native (AI/AN) persons in the United States. Testimony also noted that AI/AN individuals have very limited access to comprehensive cancer care centers and often face prohibitively expensive care requirements which leads to worse health outcomes for this population. Your Reference Committee also heard that federal Indian Health Service (IHS) facilities do not offer on-site cancer care or provide payment for cancer treatment, unlike other federal health programs like the Department of Veterans Affairs (VA), unless funds are available for referral. Moreover, your Reference Committee heard that for the ten most populated AI/AN reservations, the median travel distance to a National Cancer Institute (NCI) cancer center is 186.5 miles, and the median travel time is 3.37 hours, and that such barriers to cancer screening and treatment can often result in worse health outcomes. However, your Reference Committee also heard concerns about adopting disease-specific cancer care policies for AI/AN populations rather than broader language that continues to support access to all care and access to all specialty-specific care. Your Reference Committee heard that adopting more general policy would provide more flexibility to our AMA to advocate for improvements to AI/AN health outcomes and access to health care, including cancer care. Your Reference Committee also heard that a new resolve clause on increasing funding and technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities would be a worthwhile addition and received a proposed amendment regarding this issue. Therefore, your Reference Committee recommends that Resolution 242 be adopted as amended.

(40) RESOLUTION 247 — PROHIBIT HEALTH BENEFIT PLANS FROM CHARGING COST SHARING FOR COVERED PROSTATE CANCER SCREENING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 247 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support ~~advocate for~~ federal legislation requiring that health benefit plans may not charge any form of cost sharing for covered prostate cancer screening.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 247 be adopted as amended.

HOD ACTION: Resolution 247 adopted as amended.

RESOLVED, that our American Medical Association advocate for federal legislation requiring that health benefit plans may not charge any form of cost sharing for covered prostate cancer screening. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 247. Your Reference Committee heard that this resolution aims to address disparities in cancer screening coverage, specifically for prostate cancer, which lacks a federal mandate for no-cost screening unlike breast, cervical, and colorectal cancers. Your Reference Committee heard that prostate cancer screening using Prostate-Specific Antigen (PSA) tests is vital for early detection and significantly improves survival rates, yet cost-sharing remains a barrier for many patients. Testimony highlighted that several states have already implemented policies to remove cost-sharing for prostate cancer screening, reflecting a growing recognition of the need for equitable screening practices. However, some minor amendments were offered to broaden the resolution. Therefore, your Reference Committee recommends that Resolution 247 be adopted as amended.

(41) RESOLUTION 249 — PEDIATRIC SPECIALTY MEDICAID REIMBURSEMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve be amended by addition and deletion to read as follows:

~~RESOLVED, that our AMA include in its advocacy on budget neutrality that improvements in Medicaid payment rates are made without invoking budget neutrality (Directive to Take Action); and be it further~~

RESOLVED, That our AMA advocate for payment parity with Medicare for the same or similar services provided to pediatric patients under Medicaid; and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve be amended by deletion to read as follows:

RESOLVED, that our AMA work with ~~pediatric~~ specialty societies to develop a value-based payment model that makes pediatric specialist practices sustainable and promotes access to care and health equity among the pediatric patients (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fourth Resolve be amended by addition and deletion to read as follows:

RESOLVED, that our AMA work with interested state parties ~~stakeholders~~ to support the implementation of the value-based payment model for pediatric specialists in state Medicaid programs~~.~~, (Directive to Take Action) and be it further

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 249 be amended by addition of a fifth Resolve to read as follows:

RESOLVED, That our AMA advocate for any demonstration projects undertaken to modernize Medicaid payment using value based payment models developed by the AMA and pediatric specialty societies be exempt from Medicaid demonstration project budget neutrality requirements.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 249 be adopted as amended.

HOD ACTION: Resolution 249 adopted as amended.

RESOLVED, that our American Medical Association make increasing Medicaid reimbursement for pediatric specialists a significant part of its plan for continued progress toward health equity (Directive to Take Action); and be it further

RESOLVED, that our AMA include in its advocacy on budget neutrality that improvements in Medicaid payment rates are made without invoking budget neutrality (Directive to Take Action); and be it further

RESOLVED, that our AMA work with pediatric specialty societies to develop a value-based payment model that makes pediatric specialist practices sustainable and promotes access to care and health equity among the pediatric patients (Directive to Take Action); and be it further

RESOLVED, that our AMA work with state stakeholders to support the implementation of the value-based payment model for pediatric specialists in state Medicaid programs. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 249. Testimony addressed issues with Medicaid reimbursement rates for pediatric subspecialists and its implications on health equity. Your Reference Committee heard that there are disparities in reimbursement that currently disincentivize specialists from entering pediatric fields. Your Reference Committee was offered an amendment that requested that our AMA advocate for payment parity with Medicare to incentivize more specialists to enter this field, which received support. Additionally, testimony emphasized the need to develop and implement value-based payment models designed to make pediatric specialist practices sustainable and promote broader access to care, ultimately supporting health equity among pediatric patients. Therefore, your Reference Committee recommends that Resolution 249 be adopted as amended.

(42) RESOLUTION 252 — MODEL LEGISLATION TO PROTECT THE FUTURE OF MEDICINE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 252 be amended by addition and deletion to read as follows:

Resolved, that our American Medical Association create model state ~~and national~~ legislation to protect the ability of medical schools and residency/fellowship training programs to have diversity, equity, and inclusion (DEI) and related initiatives for their students, employees, and faculty to ensure the education and implementation of optimized healthcare.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 252 be adopted as amended.

HOD ACTION: Resolution 252 adopted as amended.

Resolved, that our American Medical Association create model state and national legislation to protect the ability of medical schools and residency/fellowship training programs to have diversity, equity, and inclusion (DEI) and related initiatives for their students, employees, and faculty.

Your Reference Committee heard mixed but mostly supportive testimony on Resolution 252. Your Reference Committee heard about the importance of diversity, equity, and inclusion (DEI) in medical school. Testimony noted the value of having DEI in medical school settings and highlighted that in certain states, DEI is not supported. Testimony also noted bills in Congress and at the state level that would restrict GME funding if schools mandate DEI initiatives. Your Reference Committee also heard that our AMA has strong policy that supports diversity in medical education including through scholarship programs, loan repayment programs, pipeline programs, early and diverse recruiting methods and more. Testimony also highlighted that our AMA has policy calling on our AMA to advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed with student and physician guidance as well as committed to community engagement. However, your Reference Committee also heard that our AMA does not create federal model legislation and was offered an amendment to that effect. An additional amendment was received that tied this resolution to the implementation of optimized healthcare and was not opposed. Therefore, your Reference Committee recommends that Resolution 252 be adopted as amended.

(43) 253 — ADDRESSING THE FAILED IMPLEMENTATION OF THE NO SURPRISES ACT IDR PROCESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 253 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 253 be changed to read as follows:

ADDRESSING THE FAILED IMPLEMENTATION OF THE NO SURPRISES ACT INDEPENDENT DISPUTE RESOLUTION PROCESS

HOD ACTION: Resolution 253 adopted with a change of title.

ADDRESSING THE FAILED IMPLEMENTATION OF THE NO SURPRISES ACT INDEPENDENT DISPUTE RESOLUTION PROCESS

Resolved, that our American Medical Association advocate for the federal departments to immediately and correctly implement the fair and timely Independent Dispute Resolution (IDR) process as stipulated by the No Suprises Act including advocating specifically for the following:

1. Specific requirements for insurers: Insurers must be required to make IDR loss payments directly to physicians, clarify IDR eligibility on explanation of benefit forms, and be prohibited from falsely claiming ineligibility due to network status or incorrect venue claims;

2. Operational improvements in the IDR process: IDR entities must not close claims based on unverified insurer claims, an adequate number of IDR entities must be certified, and a structured timeline must be set for IDR entity selection and payment process (Directive to Take Action).

Your Reference Committee heard supportive testimony on Resolution 253. Your Reference Committee heard testimony recognizing that passage of this resolution would complement continued advocacy by our AMA in this space to promote enforcement of the No Surprises Act and specifically enforcement of the Independent Dispute Resolution provisions. Therefore, your Reference Committee recommends that Resolution 253 be adopted.

RECOMMENDED FOR ADOPTION IN LIEU OF

(44) BOARD OF TRUSTEES REPORT 13 — PROHIBITING COVENANTS NOT-TO-COMPETE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Recommendations for Board of Trustees Report 13 be adopted in lieu of the Recommendations in Board of Trustees Report 13 and the remainder of the Report be filed.

1. That the AMA oppose all restrictive covenants between employers and physician employees and regularly update its state restrictive covenant legislative template. (New HOD Policy)

2. That our AMA continue to assist interested state medical associations and specialty societies in developing strategies for physician employee retention. (New HOD Policy)

HOD ACTION: Alternate Recommendations for Board of Trustees Report 13 adopted in lieu of the Recommendations in Board of Trustees Report 13 and the remainder of the Report filed.

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

1. That the American Medical Association (AMA) continue to assist interested state medical associations in developing fair and reasonable strategies regarding restrictive covenants between physician employers and physician employees including regularly updating the AMA's state restrictive covenant legislative template. (New HOD Policy)

Your Reference Committee heard mixed testimony on the recommendations of Board of Trustees Report 13. Your Reference Committee heard supportive testimony that noted the numerous recommendations concerning how non-competes might be modified in ways that promote physician mobility and access to patient care while continuing to protect the legitimate business interests of physician practice owners. However, your Reference Committee also heard a wealth of testimony against adoption and instead urged our AMA to ban all physician non-competes between employers and physician employees. This testimony emphasized many reasons to support a ban on all physician non-competes, including harm to patient care and trapping physicians in detrimental working conditions. Testimony also noted that non-competes are not effective in achieving the desired goals of physician employers.

Your Reference Committee believes that the weight of testimony supported a ban on all physician non-competes. Your Reference Committee also heard that our AMA must do

everything in its power to support and protect independent physician practices including continuing to assist interested state medical associations and national medical specialty societies develop strategies for physician employee retention. Therefore, your Reference Committee recommends that Alternate Recommendations be adopted in lieu of Board of Trustees Report 13.

(45) RESOLUTION 210 — SUPPORT FOR PHYSICIANS PURSUING COLLECTIVE BARGAINING AND UNIONIZATION
RESOLUTION 236 — SUPPORT OF PHYSICIANS PURSUING COLLECTIVE BARGAINING AND UNIONIZATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 210 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~convenes an updated~~ study ~~of~~ opportunities for the AMA or physician associations to support physicians initiating and navigating a collective bargaining process, including but not limited to unionization. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that amended Resolution 210 be adopted in lieu of Resolution 236.

HOD ACTION: Resolution 210 adopted in lieu of Resolution 236.

RESOLUTION 210

RESOLVED, that our American Medical Association convenes an updated study of opportunities for the AMA or physician associations to support physicians initiating a collective bargaining process, including but not limited to unionization. (Directive to Take Action)

RESOLUTION 236

RESOLVED, that our American Medical Association investigate avenues for the AMA and other physician associations to aid physicians in initiating and navigating collective bargaining efforts, encompassing but not limited to unionization. (Directive to Take Action)

Your Reference Committee heard testimony largely in support of Resolutions 210 and 236, both of which call on our AMA to research ways that physician associations might support physicians in the collective bargaining process, including but not limited to

unionization. Your Reference Committee also heard significant testimony indicating that collective bargaining is an important and timely issue given that physicians are increasingly becoming employed by large hospitals and health systems. While your Reference Committee heard some testimony that opposed the formation of unions, significant testimony stressed that collective bargaining or unionization can help employed physicians overcome a lack of individual bargaining power and negotiate with employers for improved working conditions and to safeguard quality patient care. Testimony emphasized that, considering the shifting landscape in this space, a study on AMA's role in supporting physicians navigating the collective bargaining process would be useful for AMA members. Your Reference Committee also heard some concerns that these Resolutions are not ripe for adoption given that there is a pending Council on Ethics and Judicial Affairs (CEJA) report on collective bargaining due at the 2024 AMA Interim Meeting. Your Reference Committee understands that this CEJA report can and will be considered in the study sought by Resolution 210 and 236 and will complement it. As such, your Reference Committee recommends that Resolution 210 be adopted as amended in lieu of Resolution 236.

(46) RESOLUTION 213 — ACCESS TO COVERED BENEFITS WITH AN OUT OF NETWORK ORDERING PHYSICIAN
RESOLUTION 245 — PATIENT ACCESS TO COVERED BENEFITS ORDERED BY OUT-OF-NETWORK PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 245 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association develop model legislation to protect patients managed by out-of-network physicians by prohibiting insurance plans from denying payment for covered services, including imaging, laboratory testing, referrals, medications, and other medically-necessary services for patients under their commercial insurance, ~~even if it is an HMO or point of service plan~~ based solely on the network participation of the ordering physician while preserving evidence based high quality care and healthcare affordability (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 245 be amended by addition to read as follows:

RESOLVED, that our AMA collaborate with other physician organizations to develop resources, toolkits, and education to support out-of-network care models. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that amended Resolution 245 be adopted in lieu of Resolution 213.

HOD ACTION: Amended Resolution 245 adopted in lieu of Resolution 213.

RESOLUTION 213

RESOLVED, that our American Medical Association develop model legislation to protect patients in direct primary care plans and non-network plans thus furthering the ability of direct primary care physicians and other out-of-network physicians to provide covered services, including imaging, laboratory testing, referrals, medications, and other medically-

necessary services for patients under their commercial insurance, even if it is an HMO or point of service plan (Directive to Take Action); and be it further

RESOLVED, that our AMA develop resources, tool kits, education, and internal experts to support direct primary care and other out-of-network models. (Directive to Take Action)

RESOLUTION 245

RESOLVED, that our American Medical Association develop model legislation to protect patients managed by out-of-network physicians by prohibiting insurance plans from denying payment for covered services, based solely on the network participation of the ordering physician (Directive to Take Action); and be it further

RESOLVED, that our AMA develop resources, toolkits, and education to support out-of-network care models. (Directive to Take Action)

Your Reference Committee heard testimony largely in support of Resolutions 245 and 213, both which have the goal of ensuring that patients being cared for by out-of-network physicians, including those in direct primary care practices, can access insurance coverage for care ordered by their out-of-network physicians. Testimony noted that such services could include imaging, laboratory testing, referrals, medications, and other medically necessary services. Your Reference Committee heard that such coverage would provide needed autonomy to physicians and patients from insurance companies in determining the best care and treatment for their patients. Your Reference Committee also heard some concerns about risks and nuances in value-based care models that the Committee believes should be considered in the development of model legislation. Your Reference Committee was offered an amendment, which was supported by the Resolution's authors, that would clarify that the goal of the resolution is the development of state model legislation and provide the opportunity for our AMA to support federal efforts. Therefore, your Reference Committee recommends that Resolution 245 be adopted as amended in lieu of Resolution 213.

(47) RESOLUTION 217 — PROTECTING ACCESS TO IVF TREATMENT
RESOLUTION 226 — PROTECTING ACCESS TO IVF TREATMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 217 be amended by addition to read as follows:

RESOLVED, that our AMA work with other interested organizations to oppose any civil or criminal legislation or ballot measures or court rulings that (a) would equate gametes (oocytes and sperm) or embryos with children, and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART) (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 217 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA, through the AMA Task Force to Preserve the Patient-Physician Relationship, report back at I-24 ~~A-25~~, on the status of, and AMA's activities surrounding, proposed ballot measures or legislation~~,~~ and pending court rulings, ~~and legislation~~ that (a) would equate gametes or embryos with children and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART). (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that amended Resolution 217 be adopted in lieu of Resolution 226.

HOD ACTION: Amended Resolution 217 adopted in lieu of Resolution 226.

RESOLUTION 217

RESOLVED, that our American Medical Association oppose any legislation or ballot measures that could criminalize in-vitro fertilization (New HOD Policy); and be it further

RESOLVED, that our AMA work with other interested organizations to oppose any legislation or ballot measures or court rulings that equate gametes (oocytes and sperm) or embryos with children (New HOD Policy); and be it further

RESOLVED, that our AMA report back at A-25, on the status of, and AMA's activities surrounding, ballot measures, court rulings, and legislation that equate embryos with children. (Directive to Take Action)

RESOLUTION 226

RESOLVED, that our American Medical Association oppose any legislation that could criminalize in-vitro fertilization (New HOD Policy); and be it further

RESOLVED, that our AMA work with other interested organizations to oppose Court rulings that equate gametes (oocytes and sperm) or embryos with children. (Directive to Take Action)

Your Reference Committee heard strong and unanimous testimony supporting the first and second resolved clauses of Resolution 217 and in support of an amendment to broaden the scope of the Resolution. Your Reference Committee heard about the importance of our AMA opposing legislation, ballot measures, and court rulings that could criminalize in-vitro fertilization (IVF) or equate gametes or embryos with children. Your Reference Committee also heard that a recent state Supreme Court decision that recognized embryos as children sets a dangerous precedent and threatens access to evidence-based reproductive care. Your Reference Committee also heard limited testimony suggesting that the resolution should be expanded to include opposing the "personhood" of fetuses as well as embryos and gametes, but alternative testimony noted that this was beyond the scope of the evidence presented in the resolution. Your Reference Committee notes that our AMA has strong and extensive policy opposing limitations and bans on access to evidence-based reproductive health services, including abortion, that already enables our AMA to oppose governmental interference in the practice of medicine due to legal recognition of fetal "personhood." Your Reference Committee also heard testimony that the third resolved clause requiring a report back is duplicative of existing policy and activities. Your Reference Committee heard that monitoring governmental interference in IVF is being already being undertaken by the AMA Task Force to Preserve the Patient-Physician Relationship, which was formed by the House of Delegates in 2022 and has 20 representatives from state and specialty medical associations and ten representatives from AMA Councils. Testimony in support of the third resolved emphasized the need for a report on Task Force's activities. Your Reference Committee notes that existing AMA policy already directs the Task Force to report back on its activities on an annual basis. Testimony also noted that Resolutions 217 and 226 were very similar and as such, only one of the resolutions was needed. Therefore, your Reference Committee recommends that Resolution 217 be adopted as amended in lieu of Resolution 226.

(48) RESOLUTION 251 — STREAMLINE PAYER QUALITY METRICS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 251 be adopted in lieu of Resolution 251.

RESOLVED, that our American Medical Association will continue to advocate for improvements in private payers' quality programs.

HOD ACTION: Alternate Resolution 251 adopted in lieu of Resolution 251.

RESOLVED, that our American Medical Association work with the Centers for Medicare and Medicaid Services and major national insurance carriers to align each year's patient quality metrics across their respective programs. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 251. Your Reference Committee heard that this resolution seeks to address the inconsistencies in quality benchmarks set by Medicare and various third-party insurance carriers, which create challenges for primary care physicians in tracking, analyzing, and meeting these measures. Your Reference Committee heard that while the Centers for Medicare and Medicaid Services (CMS) does not control the quality metrics set by private payers, it is crucial for our AMA to advocate for alignment in these quality programs to reduce administrative burdens and ensure fair evaluation of physician performance. However, your Reference Committee heard that alternatives needed to be made to this resolution so that the spirit of the resolution is maintained while at same time appropriately shifting the focus towards advocating for improvements in private payers' quality programs without placing the onus on CMS. Testimony noted that these alternatives would allow our AMA to effectively work towards consistency, compliance, communication, and access in quality measurement standards, enhancing both physician practice sustainability and patient care outcomes. Therefore, your Reference Committee recommends that Alternate Resolution 251 be adopted in lieu of Resolution 251.

RECOMMENDED FOR REFERRAL

(49) BOARD OF TRUSTEES REPORT 15 — AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE
RESOLUTION 202 — USE OF ARTIFICIAL INTELLIGENCE AND ADVANCED TECHNOLOGY BY THIRD PARTY PAYORS TO DENY HEALTH INSURANCE CLAIMS
RESOLUTION 246 — AUGMENTED INTELLIGENCE IN HEALTH CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 15, Resolution 202, and Resolution 246 be referred for report back at the 2024 Interim Meeting of the House of Delegates.

HOD ACTION: Board of Trustees Report 15, Resolution 202, and Resolution 246 referred for report back at the 2024 Interim Meeting of the House of Delegates.

BOARD OF TRUSTEES REPORT 15

The Board of Trustees recommends that the following be adopted in lieu of Resolution 206-I-23 and that the remainder of the report be filed:

AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

General Governance

- Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, and transparent.
- Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
- Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
- Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the potential overall of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in Health Care H-480.939 at (1)]
- Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan.

- Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow.
- Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies

- When AI is used in a manner which directly impacts patient care, access to care, or medical decision making, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
- When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
- AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
- When health care content is generated by generative AI, including by large language models, it should be clearly disclosed within the content that was generated by an AI enabled technology.
- When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
- The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology.

What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

- When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
    - Regulatory approval status
    - Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology
    - Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use
    - Intended population and intended practice setting

- Clear description of any limitations or risks for use, including possible disparate impact
- Description of how impacted populations were engaged during the AI lifecycle
- Detailed information regarding data used to train the model:
  - Data provenance
  - Data size and completeness
  - Data timeframes
  - Data diversity
  - Data labeling accuracy
- Validation Data/Information and evidence of:
  - Clinical expert validation in intended population and practice setting and intended clinical outcomes
  - Constraint to evidence-based outcomes and mitigation of "hallucination" or other output error
  - Algorithmic validation
  - External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation
  - Comprehensiveness of data and steps taken to mitigate biased outcomes
  - Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings
  - Post-market surveillance activities aimed at ensuring continued safety, performance, and equity
- Data Use Policy
  - Privacy
  - Security
  - Special considerations for protected populations or groups put at increased risk
- Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training
- Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review

- Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

Generative Augmented Intelligence

- Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA41 compliant Business Associate Agreement).

- Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
  - Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response
  - Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations
  - Lack of regulatory or clinical oversight to ensure performance of the tool
  - Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes
  - Data privacy
  - Cybersecurity
  - Physician liability associated with the use of generative AI tools
- Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
- Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
- Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (e.g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI driven medical advice.
- Governance policies should prohibit the use of confidential, regulated, or proprietary information as prompts for generative AI to generate content.
- Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

Physician Liability for Use of Augmented Intelligence-Enabled Technologies

- Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]
  - Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
  - Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

- Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

- When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.

Data Privacy and Augmented Intelligence

- Entity Responsibility:
  - Entities should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
  - Individuals should have the right to opt-out, update, or forget use of their data in generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
  - Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

- User Education:
  - Users should be provided with training specifically on generative AI. Education should address:
    - legal, ethical, and equity considerations;
    - risks such as data breaches and re-identification;
    - potential pitfalls of inputting sensitive and personal data; and
    - the importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

Augmented Intelligence Cybersecurity

- AI systems must have strong protections against input manipulation and malicious attacks.
- Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
- Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
- Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber

attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

Payor Use of Augmented Intelligence and Automated Decision-Making Systems

- Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
- Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
- Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
- Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
- Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
- Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
- Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of

automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

- (New HOD Policy)

RESOLUTION 202

RESOLVED, that our American Medical Association adopt as policy that Commercial third-party payors, Medicare, Medicaid, Workers Compensation, Medicare Advantage and other health plans ensure they are making medical necessity determinations based on the circumstances of the specific patient rather than by using an algorithm, software, or Artificial Intelligence (AI) that does not account for an individual's circumstances (New HOD Policy); and be it further

RESOLVED, that our AMA adopt as policy that coverage denials based on a medical necessity determination must be reviewed by a physician in the same specialty or by another appropriate health care professional for non-physician health care providers. (New HOD Policy)

RESOLUTION 246

RESOLVED, that our American Medical Association amend its augmented intelligence policy to align with the following:

Augmented Intelligence in Health Care

The American Medical Association supports the use of augmented intelligence (AI) when used appropriately to support physician decision-making, enhance patient care, improve administrative functions, and improve public health without reducing the importance of physician decision-making. Augmented intelligence also should be used in ways that reduce physician burden and increase professional satisfaction. Sufficient safeguards should be in place to assign appropriate liability inherent in augmented intelligence to the software developers and not to those with no control over the software content and integrity, such as physicians and other users. Ultimately, it is the physician's responsibility to uphold the standard of care.

The American Medical Association adopts the following principles for augmented intelligence in health care:

1. Augmented intelligence should be the preferred health care term over artificial intelligence as it should be used to augment care by providing information for consideration. Augmented intelligence, whether assistive or fully autonomous, is intended to co-exist with human decision-making and should not be used to replace physician reasoning and knowledge.
2. Physicians should not be mandated to use augmented intelligence without having input or feedback into how the tool is used either individually or as a medical staff.
3. Augmented intelligence must not replace or diminish the patient-physician relationship.

4. Algorithms developed to augment user intelligence must be designed for the benefit, safety, and privacy of the patient. The AMA should research opportunities to place practicing physicians on public and private panels, work groups, and committees that will evaluate products as they are developed.
5. Sellers and distributors of augmented intelligence should disclose that it has met all state and federal legal and regulatory compliance with regulations such as, but not limited to, those of HIPAA, the U.S. Department of Health and Human Services, and the U.S. Food and Drug Administration.
6. Use of augmented intelligence, machine learning, and clinical decision support has inherent known risks. These risks should be recognized, and legal and ethical responsibility for the use and output of these products must be assumed by, including but not limited to, developers, distributors, and users with each entity owning responsibility for its respective role in the development, dissemination, implementation, and use of products used in clinical care.
7. Users should have clear guidelines for how and where to report any identified anomalies. Additionally, as with all technology, there should be a national database for reporting errors that holds developers accountable for correcting identified issues.
8. Before using augmented intelligence, physicians and all users should receive adequate training and have educational materials available for reference, especially in instances where the technology is not intuitive and there are periods of nonuse.
9. Physicians should inquire about whether the AI used is a “continuously learning system” versus a “locked system.” A locked system is more appropriate for clinical care, although a hybrid system may be appropriate as long as the clinical output is based on locked training sets. A locked system gives a predictable output, whereas a continuous learning system will change over time.
10. Algorithms and other information used to derive the information presented as augmented intelligence to physicians and other clinicians should:

    a. Be developed transparently in a way that is accessible, explainable, and understandable to clinicians and patients and details the benefits and limitations of the clinical decision support, and/or augmented intelligence
    b. Have reproducible and explainable outputs
    c. Function in a way that promotes health equities while eliminating potential biases that exacerbate health disparities
    d. Use best practices for user-centered design that allows for efficient and satisfactory use of the technology;
    e. Safeguard patient information by employing privacy and security standards that comply with HIPAA and state privacy regulations
    f. Have a feedback loop that allows users who identify potential safety hazards to easily report problems and malfunctions as well as opportunities to report methods for improvements; and
    g. Contain a level of compatibility to allow use of information between hardware and software made by different manufacturers.

11. Medical students and residents need to learn about the opportunities and limitations of augmented intelligence as they are prepared for future medical practice.
12. The AMA will advocate, through legislation or regulation, for payment to physicians for utilization of artificial intelligence tools that have additional cost or require additional time.

13. Recognizing the rapid pace of change in augmented intelligence, it is important to continually assess and update the AMA's principles at regular intervals. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on the recommendations in BOT Report 15. Your Reference Committee heard testimony acknowledging the extensive vetting process the recommendations in BOT Report 15 underwent by the Board, Council on Legislation, various AMA business units, multiple specialty societies with expertise in AI, and external AI experts. Testimony also acknowledged that the recommendations were carefully drafted to supplement and build upon existing AMA AI policy, notably H-480.940 and H-480.939 on Augmented Intelligence in Health Care, and D-480.956 on the Use of Augmented Intelligence for Prior Authorization, along with our AMA's Privacy Principles. Testimony further commended the Board for its thoughtful analysis but expressed concerns over omissions in the report regarding the use of AI in the development of scientific literature and the feasibility of some of the transparency and disclosures recommendations. Testimony expressed concerns that the disclosure and transparency recommendations would pose additional burdens on physicians. Your Reference Committee heard testimony regarding Resolutions 202 and 246, as well as considered the substantive on-line comments, which noted that BOT 15 did not address some of the issues raised in these resolutions and comments. Testimony was further heard recommending that BOT 15 should be referred along with Resolutions 202 and 246 for further consideration. Your Reference Committees agrees and recommends referral of BOT 15 and Resolutions 202 and 246 as well as the online forum comments for report back at I-24.

(50) RESOLUTION 218 — DESIGNATION OF DESCENDANTS OF ENSLAVED AFRICANS IN AMERICA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 218 be referred.

HOD ACTION: Resolution 218 referred.

RESOLVED, that our American Medical Association work with appropriate organizations including, but not limited to, the Association of American Medical Colleges to adopt and define the term Descendants of Enslaved Africans in America and separate if from the generic terms African American and Black in glossaries and on medical school applications. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 218. Your Reference Committee heard that descendants of Enslaved Africans in America are a unique population and that it is important to disaggregate data to make sure everyone is recognized and that the data influencing policies, programs, and solutions are accurate. However, testimony also highlighted that over the last four years our AMA has been working with the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education through the Physician Data Collaborative (PDC) to establish best practices for data sharing and standards for sociodemographic data,

including race, ethnicity, and more. Your Reference Committee heard that these efforts will enable meaningful, collaborative research to better understand the dynamics of the physician workforce continuum. Your Reference Committee also heard that the Office of Management and Budget recently concluded an extensive national consultation process concerning updating race and ethnicity standards, which our AMA provided comments on, and which found that further research is needed to fully understand the implications of a designation for "descendants of enslaved Africans in America" because individuals and civil rights groups disagreed on whether or how to implement this potential revision. Your Reference Committee heard that although the resolution has merit, our AMA needs more time to understand its nuances and implications and to collaborate with our partners through the PDC to discuss and fully consider the short and long-term implications of these changes. Therefore, your Reference Committee recommends that Resolution 218 be referred.

(51) RESOLUTION 243 — DISAGGREGATION OF DEMOGRAPHIC DATA FOR INDIVIDUALS OF FEDERALLY RECOGNIZED TRIBES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 243 be referred.

HOD ACTION: Resolution 243 referred.

RESOLVED, that our American Medical Association add "Enrolled Member of a Federally Recognized Tribe" on all AMA demographic forms (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the use of "Enrolled Member of a Federally Recognized Tribe" as an additional 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); and be it further

RESOLVED, that our AMA support the Association of American Medical Colleges (AAMC) inclusion of "Enrolled Member of a Federally Recognized Tribe" on all AAMC demographic forms (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical Education (ACGME) to include "Enrolled Member of a Federally Recognized Tribe" on all ACGME demographic forms. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 243. Your Reference Committee heard that over the last four years our AMA has been working with the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education through the Physician Data Collaborative (PDC) to establish best practices for data sharing and standards for sociodemographic data, including race, ethnicity, and more. Your Reference Committee heard that these efforts will enable meaningful, collaborative research to better understand the dynamics of the physician

workforce continuum. Your Reference Committee also heard that the Office of Management and Budget (OMB) recently concluded an extensive national consultation process concerning updating race and ethnicity standards, which our AMA commented on. Testimony highlighted that the OMB ultimately decided to "remove the phrase 'who maintains tribal affiliation or community attachment' in the American Indian/Alaska Native (AI/AN) definition.... to improve estimates of the AI/AN population in Federal statistics." However, your Reference Committee also heard that there may be value in collecting data of members of a federally recognized tribe because it is a legal designation and not a racial category and therefore not subject to the recent U.S. Supreme Court decisions banning the use of race in holistic college admissions processes. Your Reference Committee heard that a potential disadvantage is that there are state recognized tribes and tribes which have lost their federal recognition who would be excluded from this data category. Your Reference Committee also heard that our AMA believed it would be beneficial to study the implications of this designation to ensure that our policy is more comprehensive and does not exclude AI/AN individuals because their tribe is not federally recognized. Testimony also noted that more time is needed to understand the nuances and implications of this resolution and to collaborate with our partners through the PDC to discuss and fully consider the short and long-term implications of these changes. Therefore, your Reference Committee recommends that Resolution 243 be referred.

RECOMMENDED FOR NOT ADOPTION

(52) RESOLUTION 225 — HUMANITARIAN EFFORTS TO RESETTLE REFUGEES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 225 not be adopted.

HOD ACTION: Resolution 225 not adopted.

RESOLVED, that our American Medical Association support increases and oppose decreases to the annual refugee admissions cap in the United States. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 225. Your Reference Committee heard that increasing refugee admission caps is an important social justice issue that will allow more individuals to enter into the United States and begin a new life here. Testimony stated that the United States should be doing more to ensure the wellbeing and safety of refugees all around the world and that this was one small step to help. However, your Reference Committee also heard that the United States is struggling to find adequate funding for necessities for citizens of the United States and that we do not have the ability to provide further monetary assistance to additional asylum seekers at this time. Additionally, testimony stated that our AMA is not an organization that focuses on immigration and does not have the background, expertise, or bandwidth to handle advocacy in this space. Furthermore, your Reference Committee heard that engaging with immigration policy at this time could be politically turbulent and could endanger our AMA's advocacy on other issues. Therefore, your Reference Committee recommends that Resolution 225 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(53) RESOLUTION 237 — ENCOURAGING THE PASSAGE OF THE PREVENTIVE HEALTH SAVINGS ACT (S.114)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA Policies D-155.994, H-425.988, H-460.894, and H-425.987 be reaffirmed in lieu of Resolution 237.

HOD ACTION: AMA Policies D-155.994, H-425.988, H-460.894, and H-425.987 reaffirmed in lieu of Resolution 237.

RESOLVED, that our American Medical Association encourages continued advocacy to federal and state legislatures of the importance of more accurately and effectively measuring the health and economic impacts of investing in preventive health services to improve health and reduce healthcare spending costs in the long term. (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm the following policy: D-155.994, "Value-Based Decision Making in the Health Care System" to encourage legislation and efforts to allow the Congressional Budget Office to more effectively project long-term budget deficit reductions and costs associated with legislation related to preventive health services. (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 237. Your Reference Committee heard that the Congressional Budget Office (CBO) was established to provide objective, nonpartisan information to support the U.S. budget process and aid Congress in making effective budget and economic policy and that the CBO is directed to estimate and project the cost of legislation approved by Congressional committees for a specified period of time, usually 10 years. In addition, your Reference Committee heard that 70 percent of U.S. health care expenditures is spent on the management and treatment of chronic disease, and that while much of the political debate around health care in the United States has focused primarily on insurance coverage and access, there has been little discussion around a true transformation of the health system, beginning with measurements of the impacts of preventive health policy. Your Reference Committee also heard an amendment offered to add a reference to "primary care" in the resolution which did not receive much support. Your Reference Committee also heard that the House of Representatives passed legislation, in a bipartisan vote, to direct the CBO to expand the scoring window to estimate the budgetary effects of legislation related to preventive health care services and that our AMA already sent a letter in support of this legislation to House leadership. Your Reference Committee further heard that our AMA already has policy, as noted in the resolution, that recognizes the value and importance of preventive services, and supports legislation and efforts that allow the CBO to more effectively project long-term budget deficit reductions and costs associated with preventive health services. Your Reference Committee heard testimony in favor of reaffirmation of these policies in lieu of adoption. Therefore, your Reference Committee recommends that existing AMA policies D-155.994, H-425.988, H-460.894, and H-425.987 be reaffirmed in lieu of Resolution 237.

Value-Based Decision-Making in the Health Care System D-155.994
1. Our AMA will advocate for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient.
2. Our AMA encourages efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress.

The US Preventive Services Task Force Guide to Clinical Preventive Services H-425.988
It is the policy of the AMA: (1) to continue to work with the federal government, specialty societies, and others, to develop guidelines for, and effective means of delivery of, clinical preventive services; and (2) to continue our efforts to develop and encourage continuing medical education programs in preventive medicine.

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

Preventive Medicine Services H-425.987
1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (C) appropriate reimbursement and coding for established preventive services.
2. Our AMA will seek legislation or regulation so that evidence-based screenings are paid for separately when provided as part of a comprehensive well-patient examination/review.

(54) RESOLUTION 244 — GRADUATE MEDICAL EDUCATION OPPORTUNITIES FOR AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA Policies H-350.977, H-350.976, and D-305.967 be reaffirmed in lieu of Resolution 244.

HOD ACTION: AMA Policies H-350.977, H-350.976, and D-305.967 reaffirmed in lieu of Resolution 244.

RESOLVED, that our American Medical Association supports policy and communication efforts to (1) advance legislative and regulatory policies and actions that establish, authorize, fund, and incentivize the creation of graduate medical education opportunities in IHS, Tribal-administered, and urban Indian health organizations and facilities and (2) establish associated partnerships with accredited medical schools and teaching hospitals (New HOD Policy); and be it further

RESOLVED, that our AMA supports collaboratively working with Tribal nations, Tribal organizations, academic medical centers, policy professionals, medical schools, teaching hospitals, coalition builders, and other stakeholders to advocate to Congress, The White House, the Department of Health and Human Services, and other government entities to establish dedicated graduate medical education funding and programs that benefit Tribal communities, increase physician training sites, and reduce physician shortages, particularly among underserved populations. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 244. Your Reference Committee heard about the importance of graduate medical education (GME) funding and the need for increased support of GME within the Indian Health Service (IHS). Testimony noted the increased health needs of the American Indian and Alaska Native (AI/AN) population and the serious need for more physician providers within these communities. However, your Reference Committee also heard that our AMA already has existing policy that guides our AMA to advance legislative and regulatory policies that bolster and fund graduate medical education opportunities in IHS, Tribal-administered, and urban Indian health organizations and facilities. Furthermore, testimony noted that our current policy also already addresses the importance of the creation and maintenance of partnerships in this space. Your Reference Committee also heard that our AMA is already engaged in this work and has signed onto multiple letters requesting more funding for IHS GME. Testimony also highlighted that our AMA has supported bills like the IHS Workforce Parity Act and asked for additional IHS GME funding and support in Statements for the Record, letters to the Administration, and comment letters. Your Reference Committee also heard that our AMA is consistently advocating for more holistic GME funding, including IHS GME funding. Your Reference Committee also notes that duplicative policy would potentially cause confusion. Therefore, your Reference Committee recommends that existing AMA policies H-350.977, H-350.976, and D-305-967 be reaffirmed in lieu of Resolution 244.

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

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

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

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Landon Combs, MD, Cheryl Gibson Fountain, MD, Tilden Childs III, MD, Matthew Burday, DO, Jennifer Hone, MD, Dayna Isaacs, MD, and all those who testified before the Committee.

Landon S. Combs, MD (Alternate)
Tennessee Medical Association

Matthew Burday, DO (Alternate)
Medical Society of Delaware

Cheryl Gibson Fountain, MD, FACOG
American College of Obstetricians and Gynecologists

Jennifer Hone, MD (Alternate)
California Medical Association

Tilden L. Childs III, MD, FACR
American College of Radiology

Dayna J. Isaacs, MD, MPH
Residents & Fellows Section

Peter H. Rheinstein, MD, JD
Academy of Physicians in Clinical Research
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-24)

Report of Reference Committee C

Cheryl Hurd, MD, MA, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 31 - The Morrill Act and its Impact on the Diversity of the Physician Workforce

2. Council on Medical Education Report 01 - Council on Medical Education Sunset Review of 2014 House of Delegates' Policies

RECOMMENDED FOR ADOPTION AS AMENDED

3. Council on Medical Education Report 02 - The Current Match Process and Alternatives

4. Resolution 304 - Spirituality in Medical Education and Practice

5. Resolution 305 - Public Service Loan Forgiveness Reform

6. Resolution 308 - Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being

7. Resolution 310 - Accountability & Transparency in GME Funding with Annual Report

8. Resolution 312 - AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians

9. Resolution 313 - CME for Rural Preceptorship

10. Resolution 314 - Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule

RECOMMENDED FOR ADOPTION IN LIEU OF

11. Resolution 307 - Access to Reproductive Health Services When Completing Physician Certification Exams

12. Resolution 319 - AMA Support of U.S. Pathway Programs

RECOMMENDED FOR REFERRAL

13. Resolution 301 - Fairness for International Medical Students

RECOMMENDED FOR REFERRAL FOR DECISION

14. Resolution 303 - Amend Policy D-275.948 Title “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training”. Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards

RECOMMENDED FOR NOT ADOPTION

15. Resolution 306 - Unmatched Graduating Physicians

16. Resolution 315 - Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations

17. Resolution 317 - Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians

18. Resolution 318 - Variation in Board Certification and Licensure Requirements for Internationally-Trained Physicians and Access to Care

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

19. Resolution 302 - The Role of Maintenance of Certification

20. Resolution 309 - Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine

21. Resolution 316 - Reassessment of Continuing Board Certification Process

22. Resolution 320 - Anti-Racism Training for Medical Students and Medical Residents

Resolution handled via the Reaffirmation Consent Calendar:

Resolution 311 – Physician Participation in Healthcare Organizations

Amendments: If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 31 – THE MORRILL ACT AND ITS IMPACT ON THE DIVERSITY OF THE PHYSICIAN WORKFORCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 31 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 31 adopted and the remainder of the report filed.

1. Amend AMA Support of American Indian Health Career Opportunities H-350.981 by addition to read:

(4) Our AMA will 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 to include training a workforce from and for these tribal nations.

(6) Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations.

2. Amend AMA Support of American Indian Health Career Opportunities D-350.976 by deletion of clause (2) as having been accomplished by this report.

~~(2) study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce.~~

3. Amend AMA Support of American Indian Health Career Opportunities D-350.976 by addition of a new clause to read:

Convene key parties, including but not limited to the Association of American Indian Physicians (AAIP) and American Indian/Alaska Native (AI/AN) tribes/entities such as Indian Health Service and National Indian Health Board, to discuss the representation of AI/AN physicians in medicine and promotion of effective practices in recruitment, matriculation, retention, and graduation of medical students.

4. Reaffirm the following policies:

a. Indian Health Service H-350.977
b. Underrepresented Student Access to US Medical Schools H-350.960
c. Strategies for Enhancing Diversity in the Physician Workforce H-200.951
d. Continued Support for Diversity in Medical Education D-295.963
e. AMA Support of American Indian Health Career Opportunities D-350.976

The recommendations in Board of Trustees Report 31-A-24 received supportive online testimony. Following the close of the online member forum, the report was reconsidered by the Board to add language to the body of the report to include information about AI/AN students at osteopathic medical schools; the recommendations of the report were not changed. Language was approved and the revised report was included in the Meeting Tote. The report received supportive in-person testimony. Your Reference Committee recommends that BOT 31-A-24 be adopted.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2014 HOUSE OF DELEGATES' POLICIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 1 be adopted and the remainder of the report be filed.

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

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

The recommendations in Council on Medical Education Report 1-A-24 did not receive any testimony. Your Reference Committee appreciates the Council's thorough review of these policies and recommends that CME 1-A-24 be adopted.

RECOMMEND FOR ADOPTION AS AMENDED

(3) COUNCIL ON MEDICAL EDUCATION REPORT 2 - THE CURRENT MATCH PROCESS AND ALTERNATIVES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 2 be amended by addition to read as follows:

(20) Encourages the piloting of innovations to the residency application process with aims to reduce application numbers per applicant, focus applicants on programs with reciprocal interest, and maximize residency placement. With support from the medical education community, successful pilots should be expanded to enhance the standardized process;

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 2 be adopted as amended and the remainder of the report be filed.

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

1. AMA Policy D-310.977, "National Resident Matching Program Reform" be amended by addition to read as follows. Our AMA:

(20) Encourages the piloting of innovations to the residency application process with aims to reduce application numbers, focus applicants on programs with reciprocal interest, and maximize residency placement. With support from the medical education community, successful pilots should be expanded to enhance the standardized process;

(21) Continues to engage the National Resident Matching Program® (NRMP®) and other matching organizations on behalf of residents and medical students to further develop ongoing relationships, improve communications, and seek additional opportunities to collaborate including the submission of suitable nominees for their governing bodies as appropriate. (Modify Current HOD Policy)

2. Reaffirm AMA Policies H-310.900 "Resident and Fellow Physicians Seeking to Transfer GME Program" and H-310.912 "Residents and Fellows' Bill of Rights." (Reaffirm HOD Policy)

3. Rescind AMA policy D-310.944, "Study of the Current Match Process and Alternatives," as having been accomplished by this report. (Rescind HOD Policy)

The recommendations in Council on Medical Education Report 2-A-24 received supportive online and in-person testimony as well as online commentary from the National Resident Matching Program® (NRMP®). Testimony included two recommendations to amend by addition. One amendment suggested language clarifying the intention of reducing the number of applications "per applicant," rather than overall reduction of applications. This was unanimously supported. Another amendment suggested language promoting negotiation power, applicant preferences, and transparency, as well as changing "on behalf of residents and medical students" language to "including residents and medical students". The author and a Section Council testified against the latter amendment because, while the NRMP® oversees the Match, issues related to negotiations and preference signaling are outside of their purview, and transparency is already in clauses 4 and 19 of D-310.977. Your Reference Committee also noted that "on behalf of" language is intentional and appropriate, as medical students and residents are included within "our AMA" and noted the necessity of acting in unity as our AMA. Your Reference Committee appreciates the history and context provided in this report and recommends that CME 2-A-24 be adopted as amended.

(4) RESOLUTION 304 - SPIRITUALITY IN MEDICAL EDUCATION AND PRACTICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second clause of Resolution 304 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association amend Policy H-160.900 to read as follows:

~~Addressing~~ Patient Spirituality in ~~Medicine~~ Medical Education and Practice

(1) Our AMA recognizes the importance of individual patient spirituality and its impact on health and encourages patient access to spiritual care services.

~~(2) Our AMA encourages the availability of education about spiritual health, defined as meaning, purpose, and connectedness, in curricula in medical school, graduate medical education, and continuing physician professional development as an integral part of whole person care, which could include:~~
~~(a) assessing spiritual health as part of the history and physical;~~
~~(b) addressing treatment of spiritual distress by the clinician, with appropriate referral to spiritual care professionals;~~
~~(c) acknowledging patients' spiritual resources;~~
~~(d) developing compassionate listening skills;~~

~~(e) ensuring ongoing follow-up of patients' spiritual health by clinicians as appropriate;~~
~~(f) describing respect for the spiritual, religious, existential, and cultural value of those they serve and understanding why it is important to not impose their own personal values and beliefs on those served; and~~
~~(g) self-reflection on one's own spirituality within professional development courses, especially as related to their vocation and wellbeing. (Modify Current HOD Policy)~~

(2) That our AMA supports promotion of medical education curricula on spiritual health.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 304 be adopted as amended.

HOD ACTION: Resolution 304 adopted as amended.

RESOLVED, that our American Medical Association amend Policy H-160.900 to read as follows:

~~Addressing~~ Patient Spirituality in ~~Medicine~~ Medical Education and Practice

(1) Our AMA recognizes the importance of individual patient spirituality and its impact on health and encourages patient access to spiritual care services.

(2) Our AMA encourages the availability of education about spiritual health, defined as meaning, purpose, and connectedness, in curricula in medical school, graduate medical education, and continuing physician professional development as an integral part of whole person care, which could include:

(a) assessing spiritual health as part of the history and physical;
(b) addressing treatment of spiritual distress by the clinician, with appropriate referral to spiritual care professionals;
(c) acknowledging patients' spiritual resources;
(d) developing compassionate listening skills;
(e) ensuring ongoing follow-up of patients' spiritual health by clinicians as appropriate;
(f) describing respect for the spiritual, religious, existential, and cultural value of those they serve and understanding why it is important to not impose their own personal values and beliefs on those served; and
(g) self-reflection on one's own spirituality within professional development courses, especially as related to their vocation and wellbeing. (Modify Current HOD Policy)

Resolution 304 received mixed online and in-person testimony. The Council on Medical Education expressed support for the concept but noted concern about the lack of

actionable steps in this resolution. To address the Council's concerns, the author offered an amendment that recommended the AMA promote a resource entitled "Spiritual Care Training for Doctors, Nurses, Chaplains, Social Workers, Psychologists—All Types of Practitioners Clinician Spiritual Care Education," which was developed and implemented since 2018 by the George Washington University Institute for Spirituality and Health's Interprofessional Spiritual Care Education Curriculum©. Further, the author recommended this resource be made available on the AMA Ed Hub™ or other appropriate place on the website. Testimony from the Council and others was supportive of this amendment. However, your Reference Committee noted concern about naming a specific curriculum in policy as opposed to the curricular topic. Therefore, your Reference Committee recommends that Resolution 304 be adopted as amended.

(5) RESOLUTION 305 - PUBLIC SERVICE LOAN FORGIVENESS REFORM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Resolution 305 be amended by addition and deletion in the third subpoint of Policy H-350.977 to read as follows:

(3) Personnel ~~Manpower~~: (a) Compensation scales for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for specialty and primary care service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing ~~manpower~~ and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served without detracting from physician compensation; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation and burnout; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Resolution 305 be amended by addition of an eighth subpoint to Policy H-350.977 to read as follows:

(8) Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program. (Modify Current HOD Policy)

RECOMMENDATION C:

Madam Speaker, Resolution 305 be amended by addition of a ninth subpoint to Policy H-350.977 to read as follows:

(9) Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 305 be adopted as amended.

HOD ACTION: Resolution 305 adopted as amended.

RESOLVED, that our American Medical Association amend Indian Health Service H-350.977 by addition and deletion as follows:

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends:

(1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal

sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3) Personnel Manpower: (a) Compensation scales for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for specialty and primary care service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served without detracting from physician compensation; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation and burnout; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

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

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

(8) Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program. (Modify Current HOD Policy)

Resolution 305 received supportive online and in-person testimony. A friendly amendment was offered to the third clause of Policy H-350.977 as the author intended to strike the word "manpower" that appears twice in the third clause. Other testimony cited concern for the immediacy proposed in the eighth clause, noting it could cause unintended consequences for the Public Service Loan Forgiveness program and Indian Health Service (IHS) (e.g., if a physician receives immediate forgiveness and then leaves the position) and offered an amendment to address this concern. The testimony also expressed concern of underfunding for IHS facilities and offered an amendment to address this concern. Hearing no opposition to the proposed amendments, your Reference Committee recommends adoption of the proposed amended language with a slight modification to align with the intent of improving access to care through IHS. Thus, your Reference Committee recommends that Resolution 305 be adopted as amended.

(6) RESOLUTION 308 - TRANSFORMING THE USMLE STEP 3 EXAMINATION TO ALLEVIATE HOUSESTAFF FINANCIAL BURDEN, FACILITATE HIGH-QUALITY PATIENT CARE, AND PROMOTE HOUSESTAFF WELL-BEING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 308 be amended by addition to read as follows:

RESOLVED, that our American Medical Association supports changing the United States Medical Licensing Examination (USMLE) Step 3 and Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 3 from a numerically-scored examination to a pass/fail examination (New HOD Policy); and be it further

RESOLVED, that our AMA supports changing USMLE Step 3 and COMLEX-USA Level 3 from a two-day examination to a one-day examination (New HOD Policy)

RESOLVED, that our AMA supports the option to take USMLE Step 3 after passing Step 2-Clinical Knowledge (CK) or take COMLEX-USA Level 3 after passing Level 2-Cognitive Evaluation (CE) during medical school (New HOD Policy)

RESOLVED, that our AMA advocates that residents taking the USMLE Step 3 or COMLEX-USA Level 3 exam be allowed days off to take the exam without having this time counted for paid time off (PTO) or vacation balance. (Directive to Take Action)
RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 308 be adopted as amended.

HOD ACTION: Resolution 308 adopted as amended.

RESOLVED, that our American Medical Association supports changing the United States Medical Licensing Examination (USMLE) Step 3 from a numerically-scored examination to a pass/fail examination (New HOD Policy); and be it further

RESOLVED, that our AMA supports changing USMLE Step 3 from a two-day examination to a one-day examination (New HOD Policy)

RESOLVED, that our AMA supports the option to take USMLE Step 3 after passing Step 2-Clinical Knowledge (CK) during medical school (New HOD Policy)

RESOLVED, that our AMA advocates that residents taking the USMLE Step 3 exam be allowed days off to take the exam without having this time counted for PTO or vacation balance. (Directive to Take Action)

Resolution 308 received supportive online and in-person testimony as well as amendments from both the Council on Medical Education and one section to include the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 3. While testimony from the Federation of State Medical Boards opposed the first three resolves, supportive testimony noted the merits of all four resolves. Your Reference Committee concurs with the inclusion of COMLEX-USA in the resolves. Your Reference Committee therefore recommends that Resolution 308 be adopted as amended.

(7) RESOLUTION 310 - ACCOUNTABILITY & TRANSPARENCY IN GME FUNDING WITH ANNUAL REPORT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 310 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~work with interested parties~~ ask federal agencies that fund graduate medical education (including but not limited to the ~~CMS, VA,~~

~~DOD,~~ Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how Direct GME ~~those~~ funds are allocated on a per resident or fellow basis, for ~~a minimum of~~ the previous ~~5~~ years ~~and be it further,~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 310 be amended by deletion to read as follows:

RESOLVED, that our AMA reaffirm policy H-305.929 ~~(Last modified 2016)~~."

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 310 be adopted as amended.

HOD ACTION: Resolution 310 adopted as amended.

RESOLVED, that our American Medical Association work with interested parties (including but not limited to the CMS, VA, DOD and others) to issue an annual report detailing the quantity of GME funding for each year including how those funds are allocated on a per resident or fellow basis, for a minimum of the previous 5 years (Directive to Take Action)

RESOLVED, that our AMA reaffirm policy H 305.929 (Last modified 2016). (Reaffirm HOD Policy)

Resolution 310 received supportive online and in-person testimony. The Council on Medical Education noted the challenges in being able to study this issue and offered an amendment to the first resolve to clarify the agencies best poised to author such a report to ensure more robust data. The author testified that the amendment offered by the Council is acceptable. Other testimony supported this amendment. Your Reference Committee concurs and recommends that Resolution 310 be adopted as amended.

(8) RESOLUTION 312 - AMA COLLABORATION WITH FSMB TO ASSIST IN LICENSING REENTRANT PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 312 be amended by addition of a second Resolve to read as follows:

RESOLVED, that our AMA supports legislative and other efforts to help offset the direct costs to physicians of participating in re-entry processes.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 312 be adopted as amended.

HOD ACTION: Resolution 312 adopted as amended.

RESOLVED, that our American Medical Association work with the FSMB, specialty and subspecialty societies, and other relevant stakeholders to study and develop evidence-based criteria for determining a physician's readiness to reenter practice and identify resources for the evaluation and retraining of physicians seeking to reenter active practice. (Directive to Take Action)

Resolution 312 received mixed online testimony and supportive in-person testimony, including the relevance of this resolution to reducing mental health stigma and supporting physicians with disabilities. One delegation opposed this resolution in online testimony but did not provide a rationale. The Federation of State Medical Boards also offered support for this resolution. One individual provided an amendment by addition of a second resolve supporting efforts to offset physicians' direct costs of re-entry. The authors were supportive of this amendment. All subsequent testimony was also supportive, citing prohibitive re-entry costs. Your Reference Committee appreciates the near-unanimous supportive testimony and recommends that Resolution 312 be adopted as amended.

(9) RESOLUTION 313 - CME FOR RURAL PRECEPTORSHIP

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 313 be amended by addition and deletion of the first resolve to read as follows:

RESOLVED, that our American Medical Association along with the Council of Medical Education, formulate a "toolkit" to teach physicians who serve as preceptors, especially in rural and underserved areas, how to be better preceptors and the process on claiming AMA Category 1 credits for preparation and teaching medical students, residents, fellows, and other allied health

professional students training in Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and /Accreditation Council for Graduate Medical Education accredited institutions, thereby making them a more effective preceptor~~; and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 313 be amended by deletion of the second and third resolves.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 313 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 313 be changed to read as follows:

~~CME FOR RURAL~~ CONTINUING MEDICAL EDUCATION RESOURCES FOR PRECEPTORSHIP

HOD ACTION: Resolution 313 adopted as amended.

RESOLVED, that our American Medical Association along with the Council of Medical Education, formulate a “toolkit” to teach physicians who serve as preceptors, especially in rural and underserved areas, how to be better preceptors and the process on claiming AMA Category 1 credits for preparation and teaching medical students, residents, fellows, and other allied health professional students training in Liaison Committee on Medical Education/Accreditation Council for Graduate Medical Education accredited institutions, thereby making them a more effective preceptor; and be it further

RESOLVED, that our AMA study formulating a plan, in collaboration with other interested bodies, to award AMA Category 1 credits to physicians who serve as preceptors in rural and underserved areas teaching medical students, residents, fellows, and other allied health professional students training in Liaison Committee on Medical Education/Accreditation Council for Graduate Medical Education accredited institutions thereby improving the rural healthcare workforce shortage; and be it further

RESOLVED, that our AMA devise a method of converting those credits awarded by other organizations into AMA recognized credits for the purpose of CME.

Resolution 313 received mixed online and in-person testimony. Your Reference Committee noted there may be confusion about the claiming of credit for precepting (all preceptorships including rural), which is addressed in the AMA PRA Booklet and related AMA resources. The Council testified that physicians can already earn *AMA PRA Category 1 Credit*™ for learning associated with teaching medical students and residents/fellows, including preceptorship, when certified as a continuing medical education (CME) activity by an accredited CME provider. Thus, study would not be necessary. Your Reference Committee observed that while the first two resolves focus on CME for preceptors, the third resolve addresses conversion of credits. Your Reference Committee noted there are three major CME credit systems for physicians, each representing its own standards for granting credit. As defined in Policy H-300.988, CME should be focused on learning. The author proposed amending their resolution to keep the first resolve, and strike the second and third resolve. Testimony was supportive of the author's amendment. Your Reference Committee agrees that information is needed to help physician preceptors better understand how to claim CME credit. Since the resolution calls upon LCME, your Reference Committee recommended adding the Commission on Osteopathic College Accreditation as well. Thus, your Reference Committee recommends that Resolution 313 be adopted as amended.

(10) RESOLUTION 314 - REDUCING THE LIFETIME EARNINGS GAP IN THE U.S. WITH SIMILAR EDUCATIONAL ATTAINMENT BY EMPLOYING THE GAINFUL EMPLOYMENT RULE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 314 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association promote awareness of the work of our AMA and American Association of Medical Colleges related to ~~collaborate with higher education authorities to research physician career outcomes and explore financial value transparency among higher educational institutional programs that grant professional and doctoral degrees beyond six years following graduation in light of the new~~ federal gainful employment regulations and transparency provisions ~~that will take effect July 1, 2024~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-305.925 be reaffirmed in lieu of the second resolve.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 314 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends a change in title of Resolution 314 to read as follows:

~~**REDUCING THE LIFETIME EARNINGS GAP IN THE U.S. WITH SIMILAR EDUCATIONAL ATTAINMENT BY EMPLOYING THE GAINFUL EMPLOYMENT RULE**~~

PROMOTE AWARENESS OF FEDERAL GAINFUL EMPLOYMENT REGULATIONS AND TRANSPARENCY PROVISIONS

HOD ACTION: Resolution 314 adopted as amended.

RESOLVED, that our American Medical Association collaborate with higher education authorities to research physician career outcomes and explore financial value transparency among higher educational institutional programs that grant professional and doctoral degrees beyond six years following graduation in light of the new gainful employment regulations and transparency provisions that will take effect July 1, 2024 (Directive to Take Action)

RESOLVED, that our AMA continue to work with key stakeholders and advocate for the resolution of the student loan crisis to protect physicians from unaffordable student debt and poor earning outcomes. (Directive to Take Action)

Resolution 314 received mixed online and in-person testimony. The Council on Medical Education's testimony noted that the Association of American Medical Colleges has been actively addressing gainful employment and related regulations, and the intent of the second resolve is represented in policy H-305.925.

Your Reference Committee recommends that the first resolve be amended to amplify awareness of ongoing efforts and to reaffirm policy H-305.925 in lieu of the second resolve. Thus, your Reference Committee recommends that Resolution 314 be adopted as amended.

Recommended by Adoption In Lieu Of

(11) RESOLUTION 307 - ACCESS TO REPRODUCTIVE HEALTH SERVICES WHEN COMPLETING PHYSICIAN CERTIFICATION EXAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 307 be adopted in lieu of Resolution 307 to read as follows:

RESOLVED that our American Medical Association encourage national specialty boards who hold in-person centralized mandatory exams for board certification to provide alternate options when those exams take place in states with laws banning or restricting abortion, gender-affirming care, or reproductive healthcare services such that travel to those states would present either a limitation in access to necessary medical care, or threat of civil or criminal penalty against the examinees and examiners.

RESOLVED that our American Medical Association study the impact of laws restricting reproductive healthcare and gender-affirming care on examinees and examiners of national specialty board exams and existing alternatives to in-person board examinations.

HOD ACTION: Alternate Resolution 307 adopted in lieu of Resolution 307.

RESOLVED, that our American Medical Association encourage national specialty boards who hold in-person centralized mandatory exams for board certification to offer alternative methods of taking mandatory board certification examinations, such as virtual boards examinations, or to locate them outside of states that are in the process of banning or restricting or that have banned or restricted abortion, gender affirming care or reproductive healthcare services. (New HOD Policy)

Resolution 307 received supportive online and in-person testimony. The Council on Medical Education agreed with the concept and noted that while the issue is timely, it is also fraught with nuances that, as written, may have negative unintended consequences. The Council offered alternate language to uphold the intent of the resolution and address the points raised about risk to one's personal health when traveling to such states as well as one's legal risk as a physician when traveling to such states. Additional testimony favored the Council's alternate language and offered amendments to it, which the Council accepted as friendly. Your Reference Committee acknowledged this is a challenging, important, and urgent issue. Your Reference Committee believes the alternate language provided by the Council and others adequately summarizes the points raised in the

resolution and in testimony while also addressing the author's desire to establish AMA policy at this meeting and allowing the Council to study the issue further. Thus, your Reference Committee recommends that Alternate Resolution 307 be adopted in lieu of Resolution 307.

(12) RESOLUTION 319 - AMA SUPPORT OF U.S. PATHWAY PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 319 be adopted in lieu of Resolution 319 to read as follows:

RESOLVED, that our American Medical Association supports development of pilot grant programs advised by a diverse body of AMA member physicians, trainees, staff, and allied organization representatives in medicine and public health (i.e., administration; grantee criteria and selection; periodic reporting) that will a) support existing and new pre-K-16 pathway, Science, Technology, Engineering, Math, and Medicine (STEMM), and pre-med programs; b) include program goals of scaling organizational grantees' ability to expand their reach among youth, increasing diversity in medicine, achieving health equity, and improving medical education; and c) convene a summit among pathway and STEMM programs regarding best practices, collaboration, and strategic planning.

HOD ACTION: Alternate Resolution 319 adopted in lieu of Resolution 319.

RESOLVED, that our American Medical Association establish a grant program to support existing and new K-16 pathway, STEMM and pre-med programs whose goals include, scaling organizational grantees' ability to expand their reach among youth; increasing diversity in medicine; achieving health equity; improving medical education (Directive to Take Action)

RESOLVED, that our AMA establish a diverse advisory body comprised of AMA member physicians and trainees, staff, and allied organization representatives in medicine and public health to co-develop the grant program (i.e., administration; grantee criteria and selection; periodic reporting) (Directive to Take Action)

RESOLVED, that our AMA convene a summit among pathway and STEMM programs regarding best practices, collaboration and strategic planning. (Directive to Take Action)

Resolution 319 received supportive online and in-person testimony. The Council on Medical Education proposed alternate language to combine the asks into one resolve while also clarifying the duties of an advisory body and highlighting the importance of

scaling success. One delegation proposed an amendment to include “pre-“ in front of K-16 to emphasize the importance of early intervention. The authors and all subsequent testimony supported the alternate language with amendment. Your Reference Committee appreciates the unanimous support of efforts to bolster early pathways to medical education and improve patient care through diversity, and therefore recommends that Alternate Resolution 319 be adopted in lieu of Resolution 319.

RECOMMENDED FOR REFERRAL

(13) RESOLUTION 301 - FAIRNESS FOR INTERNATIONAL MEDICAL STUDENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 301 be referred.

HOD ACTION: Resolution 301 referred.

RESOLVED, that our American Medical Association encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students; and be it further

RESOLVED, that our AMA amend policy H-255.968 "Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools" by addition and deletion to read as follows; and be it further

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

Our AMA:

1. supports the autonomy of medical schools to determine optimal tuition requirements for international students;
2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;
3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); ~~and~~
4. supports efforts to re-evaluate and minimize the use of pre-payment requirements specific to international medical students; and
5. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, ~~for four years~~ for covering the costs of medical school.

RESOLVED, that our AMA advocate for increased scholarship and funding opportunities for international students accepted to or currently attending United States medical schools.

Resolution 301 received mixed online and in-person testimony. Your Reference Committee acknowledges the value of international students given the diversity and experience they bring to the U.S. health care system. The Council on Medical Education testimony noted the intent of the resolution may run in conflict with the federal visa process, whereby visa applicants must explain and provide documentation on how they

will pay for all educational, travel and living costs to a consular officer for student visa approval. Testimony noted that universities could provide a Form I-20 “Certificate of Eligibility for Nonimmigrant Student Status” without requiring tuition payment for the entirety of medical school. However, concern was also expressed about the potential impact on a school’s Title IV federal financial aid funding for all students, should an international student be unable to fulfill their financial obligations and be in default. Testimony was offered to amend the resolution to include language to encourage schools to enroll in the Student and Exchange Visitor Program; however, additional testimony questioned whether a medical school may enroll independent of their parent institution. Other testimony recommended that the American Association of Colleges of Osteopathic Medicine be included. Testimony from the Council and several delegations recommended referral; however, the author felt that the proposed resolutions were sufficient as offered. Your Reference Committee appreciates the author’s perspective but has concerns about the complexities raised in testimony. Referral would include examination of increased funding opportunities inclusive of scholarships for international students accepted to U.S. medical schools and land grant institution limitations. Thus, your Reference Committee recommends that Resolution 301 be referred so that the HOD may become better informed on this issue.

RECOMMENDED FOR REFERRAL FOR DECISION

(14) RESOLUTION 303 - AMEND POLICY D-275.948 TITLE "EDUCATION, TRAINING AND CREDENTIALING OF NON-PHYSICIAN HEALTH CARE PROFESSIONALS AND THEIR IMPACT ON PHYSICIAN EDUCATION AND TRAINING". CREATION OF AN AMA TASK FORCE TO ADDRESS CONFLICTS OF INTEREST ON PHYSICIAN BOARDS.

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 303 be referred for decision.

HOD ACTION: Resolution 303 referred for decision.

RESOLVED, that our American Medical Association amend the title of policy D-275.948 by substitution and deletion as follows:
~~Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training~~ Addressing Non-physician Positions and Participation on Physician Regulatory Boards and Bodies and Potential Conflicts of Interest D-275.948 (Modify Current HOD Policy)

RESOLVED, that our AMA work with relevant stakeholders and regulatory bodies and boards involved in physician education, accreditation, certification, licensing, and credentialing to advocate for physician leadership of these regulatory bodies and boards in order to be consistent with the AMA Recovery Plan's efforts to fight scope creep, and prevent undermining physician confidence in these organizations (Directive to Take Action)

RESOLVED, that our AMA create a task force with the mission to increase physician awareness of and participation in leadership positions on regulatory bodies and boards involved in physician education, accreditation, certification, licensing, and credentialing through mechanisms including but not limited to mentorship programs, leadership training programs, board nominations, publicizing the opportunities to the membership, and creating a centralized list of required qualifications and methods to apply for these positions. (Directive to Take Action)

Resolution 303 received mixed online and in-person testimony. The Council on Medical Education and the Board of Trustees testified to the vital relationships the AMA has with organizations who may be led by non-physicians at varying points in time. Both testified in favor of referral for decision. The Federation of State Medical Boards testified in opposition that licensing boards have public members who are equal members and can serve in leadership. Given those relationships are imperative to the work and credibility of the AMA, your Reference Committee expressed concern for the possibility of unintended consequences of this resolution. Thus, your Reference Committee recommends that

Resolution 303 be referred for decision to allow the Board of Trustees to determine the best path forward with this sensitive matter.

RECOMMENDED FOR NOT ADOPTION

(15) RESOLUTION 306 - UNMATCHED GRADUATING PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 306 be not adopted.

HOD ACTION: Resolution 306 referred.

RESOLVED, that our American Medical Association Board of Trustees study the role these unmatched physicians can play in providing care to our patients, their impact of lessening the impact of physician shortages, and provide recommendations on how to enroll these graduating physicians with a uniform title, privileges, geographic restrictions, and collaboration choices, and report to the House of Delegates at the next Interim meeting. (Directive to Take Action)

Resolution 306 received mixed online testimony including opposition from the Council on Medical Education, citing concerns about the multifactorial and nuanced problem of the physician shortage as well as variances in state laws related to non-physician providers. The Council also cited their report, "Addressing the Increasing Number of Unmatched Medical Students" (CME 3-A-16) resulting in Policy D-310.997 that "(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match." The Council also testified that alternate pathways are deeply problematic when it comes to patient safety and physician education as these pathways circumvent ACGME standards which are for the benefit of patient safety. These concerns were echoed by multiple delegations. These alternative pathways, which have already been studied by this Council, have great potential to undermine both the education and training of thousands of other physicians, and our AMA's current efforts to stop scope creep.

The purported impetus for many of these pathways is to ameliorate physician shortages, but this is once again very concerning as this effectively creates a two-tiered healthcare system where one set of patients have the potential to receive significantly lower quality care. Some delegations testified that legislation has been introduced to create alternative pathways to licensure in their states. One delegation testified that they are about to launch a bridge program that will provide a permit to unmatched medical graduates while still requiring them to reapply for residency and would like time to be able to report back on the outcomes of that program. Another delegation testified in opposition stating the average age of a physician in rural communities is 59 years, with one in three physicians planning to retire in the next five years, and that there are not sufficient mentors available for the unmatched medical graduates in rural areas resulting in subquality training of these unmatched medical graduates. Several individuals testified in opposition calling out the

existential threat to our system of education and risk of reducing the distinction between physicians and non-physician providers.

Your Reference Committee is sympathetic to the concerns raised during testimony and acknowledges that there are a myriad of reasons why medical graduates do not match, which are also referenced in report CME 3-A-21. Thus, your Reference Committee recommends that Resolution 306 be not adopted.

(16) RESOLUTION 315 - CEASE REPORTING OF TOTAL ATTEMPTS OF USMLE STEP1 AND COMLEX-USA LEVEL 1 EXAMINATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 315 be not adopted.

HOD ACTION: Resolution 315 referred.

RESOLVED, that our American Medical Association advocate that NBME and NBOME cease reporting the total number of attempts of the STEP1 and COMLEX-USA Level 1 examinations to residency and fellowship programs and licensure. (Directive to Take Action)

Resolution 315 received mixed online and in-person testimony as well as commentary from the National Board of Osteopathic Medical Examiners. Your Reference Committee heard testimony of personal stories related to failing USMLE Step 1 and is sensitive to reports of stress and the perceived possible impact on career advancement. However, many others testified about the importance of transparency, as the number of exam failures is often not used as a screening tool but rather informs holistic review and precision education, and determines residency program resource needs when supporting learners in their programs. In addition, due to evidence-based correlation of USMLE Step 1 with passing board exams, absence of remediation for residents could also impact residency program accreditation. Your Reference Committee also heard testimony regarding current state laws requiring the reporting of exam attempts. One section offered an amendment by addition to eliminate use of the number of attempts on licensure exams to impact licensure. Your Reference Committee heard concerns regarding public safety perceptions and scope of practice concerns when advocating for increased numbers of exam attempts. Your Reference Committee appreciates the perspectives offered on both sides of this issue and emphasizes that our AMA has existing policy, such as Policy D-200.985, recommending the use of holistic review processes, of which exam results are one of a constellation of information used in the review process. Your Reference Committee also expressed concerns of unintended consequences to minoritized groups where lack of attempts reported may lead to inappropriate assumptions of multiple failures or redirect bias to other areas. Your Reference Committee recommends that Resolution 315 not be adopted.

(17) RESOLUTION 317 - PHYSICIAN PARTICIPATION IN THE PLANNING AND DEVELOPMENT OF ACCREDITED CONTINUING EDUCATION FOR PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 317 be not adopted.

HOD ACTION: Resolution 317 not adopted.

RESOLVED, that our American Medical Association petition the Accredited Continuing Medical Education to develop policies which require physician participation in the planning and development of accredited continuing education for physicians. (Directive to Take Action)

Resolution 317 received mixed online and in-person testimony. Supportive testimony emphasized scope of practice concerns, while opposing testimony noted unintended consequences such as enforcement challenges, requirements of increased documentation, and work by CME providers and physician faculty. The Council on Medical Education proposed an amendment changing language from “require” to “encourage,” and noted the occasional possibility where physician involvement may not be necessary or desirable. The authors opposed this amendment. Your Reference Committee acknowledged that the Accreditation Council for Continuing Medical Education already requires CME to align with appropriate physician competencies and noted examples where curricula developed by specialized non-physicians, such as PhDs, law enforcement, and other experts, proved to be useful for physicians. In these cases, this resolution could prevent physicians from obtaining CME credit for their learning. Your Reference Committee also discussed concerns that the language of the resolution may not necessarily ensure significant physician engagement beyond cursory approval, nor ensure quality content, and may disproportionately affect smaller-budget CME providers. Your Reference Committee strongly supports physician involvement in CME planning and development, but does not believe it should be a universal requirement. Thus, your Reference Committee recommends that Resolution 317 be not adopted.

(18) RESOLUTION 318 - VARIATION IN BOARD CERTIFICATION AND LICENSURE REQUIREMENTS FOR INTERNATIONALLY-TRAINED PHYSICIANS AND ACCESS TO CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 318 be not adopted.

HOD ACTION: Resolution 318 not adopted.

RESOLVED, that our American Medical Association work with the American Board of Medical Specialties to study the variation in board certification requirements for

internationally trained physicians as well as the impact this may have on physician practices and addressing physician shortages including the impact of these pathways on maintaining public assurance of a well-trained physician workforce (Directive to Take Action)
RESOLVED, that our AMA study the potential effects of increasing access to board certification for internationally-trained physicians on projected physician workforce shortages (Directive to Take Action)

RESOLVED, that our AMA work with the Federation of State Medical Boards to study the existing alternate pathways to licensure for physicians who have not completed an ACGME-accredited post-graduate training program and the positive and negative impacts of these pathways on addressing physician shortages. (Directive to Take Action)

Resolution 318 received opposing online testimony from the Council on Medical Education and received mixed in-person testimony. The Federation of State Medical Boards (FSMB) offered conceptual support of Resolve 3. The authors, one delegation, and an individual expressed support, while the Council noted a study is already underway by the recently formed Advisory Commission on Alternate Licensing Models, of which the AMA is an active member with FSMB, American Board of Medical Specialties, Accreditation Council for Graduate Medical Education and Intealth (formerly Educational Commission for Foreign Medical Graduates). One delegation concurred with the Council regarding the need for adequate time to allow for deliberation and emphasized medical education's responsibility to the public regarding ensuring high professional standards. One caucus proposed an amendment modifying language to generally state AMA's work with relevant organizations but sought a report back by I-24. Your Reference Committee appreciates the importance of these issues, particularly for IMGs as well as the physician workforce, and notes the AMA is a key member of the Advisory Commission, which is already conducting the desired work. Your Reference Committee was informed that this Advisory Commission is expected to release recommendations, guidance, and resources in approximately a year, and that a Council report at I-24 would not be informative as we wait for the Advisory Commission report. Thus, your Reference Committee recommends that Resolution 318 be not adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(19) RESOLUTION 302 - THE ROLE OF MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-275.954, H-275.924, and H-275.926 be reaffirmed in lieu of Resolution 302.

HOD ACTION: Policies D-275.954, H-275.924, and H-275.926 reaffirmed in lieu of Resolution 302.

RESOLVED, that our American Medical Association adopt a policy that states that maintenance of certification requirements should not be duplicative of continuing medical education requirements and not be used to determine or dictate hospital privileges, insurance network credentialing, or hiring practices (New HOD Policy)

RESOLVED, that our AMA recognizes the importance of fostering competition in the market for board certification, allowing physicians to have the autonomy to choose the most suitable pathway for their individual learning and professional development needs (New HOD Policy)

RESOLVED, that our AMA undertake a comprehensive review of the available evidence concerning the impact of maintenance of certification on the quality and safety of patient care and report the findings of this investigation to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy with a report back to the House of Delegates by Annual 2025 (Directive to Take Action)

Resolution 302 received mixed online and in-person testimony. The Council on Medical Education noted that Policies D-275.954, H-275.924, and H-275.926 address the points raised in this resolution. Your Reference Committee acknowledges the author's concerns regarding continuing board certification (CBC; formerly MOC) and appreciates the Council's ongoing monitoring of CBC and collaboration with related external organizations in order to participate in its evolution. The Council and others noted in testimony that MOC/CBC has been studied annually for many years, most recently at I-23. Your Reference Committee was informed that those reports are available on the Council's webpage as well as in the AMA's Council Report Finder search engine. Testimony also noted that AMA actively participated in the American Board of Medical Specialties (ABMS) Vision Commission, charged with reviewing continuing certification within the current context of the medical profession. In CME 2-I-23, the Council concluded that "in the event of significant changes to CBC impacting practicing physicians, the Council will consider initiating a report to the House of Delegates." Your Reference Committee agrees with the Council and therefore recommends that Policies D-275.954, H-275.924, and H-275.926 be reaffirmed in lieu of Resolution 302.

(20) RESOLUTION 309 - DISAFFILIATION FROM THE ALPHA OMEGA ALPHA HONOR MEDICAL SOCIETY DUE TO PERPETUATION OF RACIAL INEQUITIES IN MEDICINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-310.945 be reaffirmed in lieu of Resolution 309.

HOD ACTION: Resolution 309 referred.

RESOLVED, that our American Medical Association recognizes that the Alpha Omega Alpha Honor Medical Society disproportionately benefits privileged trainees (New HOD Policy)

RESOLVED, that our AMA supports institutional disaffiliation from the Alpha Omega Alpha Honor Medical Society due to its perpetuation of racial inequities in medicine (New HOD Policy)

RESOLVED, that our AMA recognizes that the Alpha Omega Alpha Honor Medical Society perpetuates and accentuates discrimination against trainees of color that is inherent in medical training. (New HOD Policy)

Resolution 309 received mixed online and in-person testimony. Your Reference Committee heard passionate testimony about historical inequities exhibited by Alpha Omega Alpha (AOA) Honor Medical Society. An amendment was offered in the online testimony to add an osteopathic medical honor society to this resolution. Testimony also noted that such inequities may be a chapter level problem. The Council on Medical Education noted that the broader issue has been studied and addressed in its report CME 2-I-22, which considered the potential of bias fostered by several honor societies including AOA, resulting in policy D-310.945. The Council recommended this policy be reaffirmed in lieu of this resolution. One individual testified to AMA's own history of 132 years of discrimination that we have only recently begun to rectify and suggested a restorative justice informed approach to address past and current harms. Another individual testified that the AOA has recently secured new leadership six months ago and requested time for that leader to demonstrate AOA's commitment to diversity, equity and belonging.

Your Reference Committee is sensitive to the concerns raised by the author and others, but expressed unease with admonishing a specific organization rather than focusing on restorative justice, especially when the organization is demonstrating efforts towards correcting its past discriminatory actions. Further, your Reference Committee acknowledges our AMA's history of inequities which we have only recently begun to rectify. We have asked physicians and patients to extend grace to our AMA for our past wrongs; we should demonstrate this same grace to our colleagues who are also seeking to reform. Additionally, calling for disaffiliation from AOA could induce reputational risk to the AMA when amenable relationships are needed to encourage and assist such groups to collaborate with us to build a diverse physician workforce. Your Reference Committee notes that D-310.945 calls for equitable processes that foster reform, including the role of

honor societies. Therefore, your Reference Committee recommends that D-310.945 be reaffirmed in lieu of Resolution 309.

(21) RESOLUTION 316 - REASSESSMENT OF CONTINUING BOARD CERTIFICATION PROCESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-275.954 and H.275.924 be reaffirmed in lieu of Resolution 316.

HOD ACTION: Policies D-275.954 and H.275.924 reaffirmed in lieu of Resolution 316.

RESOLVED, that our American Medical Association undertake a thorough review and analysis of the available literature, data, and evidence to re-examine and update the accepted standards for continuing board certification including policy H-275.926, Medical Specialty Board Certification Standards, so the standards reflect the best manner to assess physicians' knowledge and skills necessary to practice medicine. (Directive to Take Action)

Resolution 316 received mixed online and in-person testimony. The Council on Medical Education recommended that policies D-275.954 and H.275.924 be reaffirmed in lieu of this item since they address the intent of this resolution. The Council and others noted in testimony that MOC/CBC has been studied annually for many years, most recently at I-23. Your Reference Committee was informed that those reports are available on the Council's webpage as well as in the AMA's Council Report Finder search engine. In the Council's I-23 report, Update on Continuing Board Certification (CME 2-I-23), the Council concluded that "in the event of significant changes to CBC impacting practicing physicians, the Council will consider initiating a report to the House of Delegates." The author testified in favor of a more granular study of CBC. Your Reference Committee noted that Policy H-275.924 establishes AMA principles for continuing board certification (CBC, formerly MOC) and Policy D-275.954 elucidates in 40 clauses all the ways it will collaborate with key organizations, review the evolving literature, and inform the HOD. Other testimony supported reaffirmation in lieu of this resolution. Your Reference Committee agrees and therefore recommends that Policies D-275.954 and H.275.924 be reaffirmed in lieu of Resolution 316.

(22) RESOLUTION 320 - ANTI-RACISM TRAINING FOR MEDICAL STUDENTS AND MEDICAL RESIDENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-65.952 be reaffirmed in lieu of Resolution 320.

HOD ACTION: Policy H-65.952 reaffirmed in lieu of Resolution 320.

RESOLVED, that our American Medical Association advocate that the Liaison Committee on Medical Education and Association of American Medical Colleges require, rather than encourage, anti-racism training for medical students and medical residents. (Directive to Take Action)

Resolution 320 was not posted in the online forum. There was mixed testimony during the live hearing. The Council on Medical Education noted that the AMA has a long-standing history of not supporting curricular mandates. There was unanimous support for medical students and medical residents receiving anti-racism training. There were significant concerns for the legal and professional consequences that may be experienced by academic physicians if anti-racism training became a requirement in schools where it is prohibited by law. The Council pointed out that it is not the purview of the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), the Liaison Committee on Medical Education (LCME), nor the Commission on Osteopathic College Accreditation (COCA), to "require" specific curriculum. Rather, the LCME and COCA promulgate standards for medical education programs to achieve and maintain accreditation. LCME Standard 7.6, Structural Competence, Cultural Competence, and Health Inequities and COCA Element 6.12: Diversity, Equity, and Inclusion Curriculum both address how schools may incorporate this education into the curriculum, where permitted by law.

Your Reference Committee is sympathetic to the concerns raised during the hearing. Additionally, your Reference Committee discussed how adoption of this resolution may negatively impact academic physicians, including those from historically excluded groups, who include anti-racism in the curriculum. This could negatively affect students, whose learning experiences may be impacted by loss of faculty. Your Reference Committee is sensitive to the concerns that physicians may experience personal, career, and legal risks which could further reduce the number of physicians from historically excluded groups in academic medicine to below its already suboptimal rate. Further, your Reference Committee is aware of the legal implications this resolution could have on some institutions, whereby the funding of medical education could be under threat if such curriculum were to be implemented. Your Reference Committee noted that the AMA has existing policy that is supportive of the intent of this resolution, such as Policy H-65.952. Additionally, the AMA, AAMC and AACOM provide curricular resources on anti-racism education. Thus, your Reference Committee recommends that Policy H-65.952 be reaffirmed in lieu of Resolution 320.

Madam Speaker, this concludes the report of Reference Committee C. I would like to thank members Christine Kim, MD, Kevin McKinney, MD, Rianna McNamee, Christopher Wee, MD, David Whalen, MD, Emily Volk, MD; staff persons Lena Drake, Tanya Lopez, Richard Pan, MD, and Amber Ryan; as well as all those who testified before the Committee.

Christine Kim, MD
American College of Radiology

Christopher Wee, MD
Ohio State Medical Association

Kevin McKinney, MD
Texas Medical Association

David Whalen, MD
Michigan State Medical Society

Rianna McNamee
Medical Society of New Jersey

Emily Volk, MD
College of American Pathologists

Cheryl Hurd, MD, MA
American Psychiatric Association
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-24)

Report of Reference Committee D

Dale M. Mandel, MD, Chair

Your reference committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 22 - AMA Public Health Strategy: Update
2. Council on Science and Public Health Report 11 – Stand Your Ground Laws
3. Resolution 401 - Addressing Social Determinants of Health Through Closed Loop Referral Systems
4. Resolution 405 - Default Proceed Firearm Sales and Safe Storage Laws
5. Resolution 408 - Indian Water Rights
6. Resolution 414 - Addressing the Health Sector's Contributions to the Climate Crisis
7. Resolution 415 - Building Environmental Resiliency in Health Systems and Physician Practices
8. Resolution 418 - Early and Periodic Eye Exams for Adults
9. Resolution 429 - Assessing and Protecting Local Communities from the Health Risks of Decommissioning Nuclear Power Plants
10. Resolution 435 - Radiation Exposure Compensation

RECOMMENDED FOR ADOPTION AS AMENDED

11. Council on Science and Public Health Report 3 - Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders
12. Council on Science and Public Health Report 6 - Greenhouse Gas Emissions from Metered Dose Inhalers and Anesthetic Gases
13. Council on Science and Public Health Report 9 - Prescribing Guided Physical Activity for Depression and Anxiety
14. Council on Science and Public Health Report 13 – Decreasing Youth Access to E-Cigarettes
15. Resolution 403 - Occupational Screenings for Lung Disease
16. Resolution 406 - Opposition to Pay-to-Stay Incarceration Fees
17. Resolution 407 - Racial Misclassification
18. Resolution 409 - Toxic Heavy Metals
19. Resolution 410 - Access to Public Restrooms
20. Resolution 411 - Missing and Murdered Indigenous Persons
21. Resolution 412 - Lithium Battery Safety

22. Resolution 416 - Furthering Environmental Justice and Equity
23. Resolution 420 - Equity in Dialysis Care
24. Resolution 422 - Immunization Registry
25. Resolution 424 - LGBTQ+ Senior Health
26. Resolution 425 - Perinatal Mental Health Disorders among Medical Students and Physicians
27. Resolution 428 - Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals
28. Resolution 430 - Supporting the Inclusion of Information about Lung Cancer Screening within Cigarette Packages
29. Resolution 432 - Resolution to Decrease Lead Exposure in Urban Areas
30. Resolution 433 - Improving Healthcare of Rural Minority Populations

RECOMMENDED FOR ADOPTION IN LIEU OF

31. Resolution 417 - Reducing Job-Related Climate Risk Factors
    Resolution 419 - Addressing the Health Risks of Extreme Heat
32. Resolution 423 - HPV Vaccination to Protect Healthcare Workers over Age 45

RECOMMENDED FOR REFERRAL

33. Council on Science and Public Health Report 10 – Teens and Social Media
34. Resolution 402 - Guardianship and Conservatorship Reform
35. Resolution 404 - Protections Against Surgical Smoke Exposure
36. Resolution 427 - Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals

RECOMMENDED FOR REFERRAL FOR DECISION

37. Resolution 421 - Annual Conference on the State of Obesity and its Impact on Disease in America (SODA)
38. Resolution 426 - Maternal Morbidity and Mortality: The Urgent Need to Help Raise Professional and Public Awareness and Optimize Maternal Health – A Call to Action

RECOMMENDED FOR NOT ADOPTION

39. Resolution 434 - Universal Newborn Eye Screening

Amendments
If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 22 - AMA PUBLIC HEALTH STRATEGY: UPDATE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 22 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 22 be adopted and the remainder of the report filed.

Informational Board of Trustees Report.

Your Reference Committee heard unanimously supportive testimony for this report. Those who testified commended the activities as outlined in the report, but noted they would like to see more detail in future reports on a strategy to strengthen public health infrastructure as well as a focus on training, inclusive of preventive medicine training. Therefore, your Reference Committee recommends that the Board of Trustees Report 22 be adopted.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 11 – STAND YOUR GROUND LAWS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendations in Council on Science and Public Health (CSAPH) Report 11 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health 11 be adopted and the remainder of the report filed.

The Council on Science and Public Health recommends that the following be adopted and the remainder of this report be filed.

1. That Policy H-145.966, “Stand Your Ground Laws” be adopted by addition and deletion to read as follows:

Our American Medical Association opposes stand your ground laws, which remove the duty to retreat before using lethal force if a person feels there is imminent risk of bodily harm, as these laws have been shown to increase homicide and homicide firearm rates and there is evidence of racial inequity in the implementation of the laws.

Our AMA supports continued study of the public health implications of “Stand Your Ground” laws and castle doctrine.

2. That Policies H-145.997, “Firearms as a Public Health Problem in the United States - Injuries and Death,” D-145.995, “Gun Violence as a Public Health Crisis,” H-145.975, “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” and D-145.999 “Epidemiology of Firearm Injuries” be reaffirmed. (Reaffirm HOD Policy)

Your Reference Committee heard testimony that was unanimously supportive of this report. The available evidence demonstrates that stand your ground laws increase homicides and firearm homicides, resulting in preventable violent deaths. The application of these laws also likely results in racial inequities. With this data in mind, it was noted that opposition to these laws is warranted. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 11 be adopted.

(3) RESOLUTION 401 – ADDRESSING SOCIAL DETERMINANTS OF HEALTH THROUGH CLOSED LOOP REFERRAL SYSTEMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 401 be <u>adopted</u>.

HOD ACTION: Resolution 401 be <u>adopted</u>.

RESOLVED, that our American Medical Association study the effectiveness and best practices of closed loop referral systems in addressing social determinants of health (Directive to Take Action).

Your Reference Committee heard supportive testimony on this item. Supportive testimony noted that a study on how closed loop referral systems can be used to address social determinants of health would help improve access to health care in populations who historically lack access and is timely. An amendment was proffered to include a report back at A-25. Your Reference Committee would like to note that this addition is not necessary because adoption of this item would result in a report back at A-25. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 401 be adopted.

(4) RESOLUTION 405 – DEFAULT PROCEED FIREARM SALES AND SAFE STORAGE LAWS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 405 be <u>adopted</u>.

HOD ACTION: Resolution 405 be <u>adopted</u>.

RESOLVED, that our American Medical Association amend Policy H-145.996, “Firearm Availability,” by addition as follows; and be it further

Firearm Availability H-145.996

1. Our American Medical Association
    a. advocates a waiting period and background check for all firearm purchasers;
    b. encourages legislation that enforces a waiting period and background check for all firearm purchasers;
    c. opposes firearm sales to individuals for whom a background check has not been completed;
    d. opposes destruction of any incomplete background checks for firearm sales;
    e. advocates for public annual reporting by relevant agencies on inappropriate firearm sales, including number of default proceed sales; number of firearms retrieved from individuals after these sales through criminal investigations, across state lines, or via other means; and average time passed between background check completion and retrieval; and
    f. urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.
3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
4. Our AMA advocates for;
    a. federal and state policies that prevent inheritance, gifting, or transfer of ownership of firearms without adhering to all federal and state requirements for background checks, waiting periods, and licensure;
    b. federal and state policies to prevent “multiple sales” of firearms, defined as the sale of multiple firearms to the same purchaser within five business days; and
    c. federal and state policies implementing background checks for ammunition purchases.

RESOLVED, that our American Medical Association amend Policy H-145.990, “Prevention of Firearm Accidents in Children,” by addition as follows:

Prevention of Firearm Accidents in Children H-145.990
1. Our American Medical Association supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to:
    a. inquire as to the presence of household firearms as a part of childproofing the home;
    b. educate patients to the dangers of firearms to children;
    c. encourage patients to educate their children and neighbors as to the dangers of firearms; and
    d. routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms.
2. Our AMA encourages state medical societies to work with other organizations to increase public education about firearm safety.
3. Our AMA encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children.

4. Our AMA supports enactment of Child Access Prevention laws and other types of comprehensive safe storage laws that are consistent with AMA policy.
5. Our AMA and all interested medical societies will educate the public about:
a. best practices for firearm storage safety;
b. misconceptions families have regarding child response to encountering a firearm in the home; and
c. the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter.

Your Reference Committee heard testimony that was unanimously supportive of this resolution, which expands existing AMA policy on background checks to end default proceed sales and expands existing policy on secure firearm storage beyond child access protection laws. With firearm deaths continuing to rise, your Reference Committee agrees with these additions to AMA policy to promote health and prevent unintentional firearm deaths, suicide, and homicide. Therefore, your Reference Committee recommends that Resolution 405 be adopted.

(5) RESOLUTION 408 – INDIAN WATER RIGHTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 408 be adopted.

HOD ACTION: Resolution be 408 be adopted.

1. Our American Medical Association will raise awareness about ongoing water rights issues for federally-recognized American Indian and Alaska Native Tribes and Villages in appropriate forums.

2. Our AMA supports improving access to water and adequate sanitation, water treatment, and environmental support and health services on American Indian and Alaska Native trust lands.

Your Reference Committee heard unanimously supportive testimony on Resolution 408 as written from multiple delegations. Therefore, your Reference Committee recommends that Resolution 408 be adopted.

(6) RESOLUTION 414 – ADDRESSING THE HEALTH SECTOR'S CONTRIBUTIONS TO THE CLIMATE CRISIS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 414 be adopted.

HOD ACTION: Resolution be 414 be adopted.

RESOLVED, that our American Medical Association recognizes that clinical quality and safety should not be sacrificed as strategies for reducing greenhouse gasses and waste (New HOD Policy); and be it further

RESOLVED, that our AMA recognizes that animal-based agriculture is a significant contributor to greenhouse gas emissions and supports efforts to increase and promote plant-based menu options in hospital food services, for both health and environmental reasons (New HOD Policy); and be it further

RESOLVED, that our AMA expects that health systems will provide transparency and avoid misleading the public regarding their greenhouse gas emissions, including but not limited to providing definitions used in the calculations of their net-zero emissions (New HOD Policy); and be it further

RESOLVED, that our AMA opposes corporate "greenwashing," or the act of making misleading statements about the environmental benefits of products and/or services (New HOD Policy); and be it further

RESOLVED, that our AMA supports the development of locally managed and reliable electrical microgrids that operate independently from the larger electrical grid for hospitals and other health care facilities to use as a way to reduce reliance on diesel generation for back-up services while maintaining critical care functions during emergencies and supports grants being provided to independent practices to facilitate this development (New HOD Policy); and be it further

RESOLVED, that our AMA support the use of virtual health care, where appropriate, with reasonable reimbursement, as a strategy to reduce the carbon footprint of health care (New HOD Policy); and be it further

RESOLVED, that our AMA support financial assistance for health care entities, including community health centers, clinics, rural health centers, small- and medium-sized physician practices, transitioning to environmentally sustainable operations (New HOD Policy); and be it further

RESOLVED, that our AMA support the development of concise clinical guidelines and patient education materials to assist physician practices and patients to reduce adverse organizational and personal impacts on climate change. (New HOD Policy)

Your Reference Committee heard unanimously supportive testimony on this resolution. Testimony noted the large contribution of the health care sector in producing greenhouse gas emissions and that this new resolution calls out strategies for health care system decarbonization and resiliency that are not currently addressed in AMA policy. Several of those testifying specifically noted the importance of supporting efforts to offer plant-based meals as the default option due to the large greenhouse gas contributions of our food production system and potential cost savings to health systems. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 414 be adopted.

(7) RESOLUTION 415 – BUILDING ENVIRONMENTAL RESILIENCY IN HEALTH SYSTEMS AND PHYSICIAN PRACTICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 415 be adopted.

HOD ACTION: Resolution 415 be adopted.

1. Our American Medical Association supports a resilient, accountable health care system capable of delivering effective and equitable care in the face of changing health care demands due to climate change.
2. Our AMA encourages health care organizations to develop climate resilience plans, for the continuity of operations in an emergency, that take into account the needs of groups in their community that experience disproportionate risk of climate-related harm and ensure the necessary collaboration between different types of healthcare facilities.
3. Our AMA recognizes that climate resilience and mitigation efforts will be community-specific and supports physician engagement at the local level to promote community alliances for environmental justice and equity.

Your Reference Committee heard limited but unanimously supportive testimony on this resolution. Testimony noted the importance of health care resiliency in the face of increasing extreme weather events because of climate change. Hospital resiliency plans are an essential component of preparedness planning to ensure the continuity of operations during emergencies and to promote health equity for those communities at disproportionate risk of climate-related harms. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 415 be adopted.

(8) RESOLUTION 418 – EARLY AND PERIODIC EYE EXAMS FOR ADULTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 418 be adopted.

HOD ACTION: Resolution 418 be adopted.

RESOLVED, that our American Medical Association (AMA) amend policy H-25.990 “Eye Exams for the Elderly” by addition to read as follows**:**

Eye Exams for the Elderly and Adults H-25.990

1. Our American Medical Association encourages the development of programs and/or outreach efforts to support periodic eye examinations and access to affordable prescription eyeglasses for elderly patients and adults who suffer from chronic systemic conditions that increase their likelihood of developing eye disease as well as a baseline eye examination for all adults aged 40 and above.
2. Our AMA encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.

Your Reference Committee heard testimony in support of this resolution. It was noted that this resolution would align AMA policy to the American Academy of Ophthalmology’s preferred practice pattern guidelines and would improve early detection of disease, which is crucial. Your Reference Committee recommends that Resolution 418 be adopted.

(9) RESOLUTION 429 – ASSESSING AND PROTECTING LOCAL COMMUNITIES FROM THE HEALTH RISKS OF DECOMMISSIONING NUCLEAR POWER PLANTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 429 be adopted.

HOD ACTION: Resolution 429 be adopted.

Our American Medical Association will advocate for strict limitations of aerosol, soil, and/or water radionuclide releases in the decommissioning of US nuclear power plants in order to protect health, particularly that of local vulnerable populations.

Your Reference Committee heard very limited but supportive testimony in favor of this resolution. Testimony highlighted the long history of health concerns for those living in close proximity to nuclear power plants, who often have limited resources. Therefore, your Reference Committee recommends that Resolution 429 be adopted.

(10) RESOLUTION 435 – RADIATION EXPOSURE COMPENSATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 435 be adopted.

HOD ACTION: Resolution 435 be adopted.

Our American Medical Association supports continued authorization of federal radiation exposure compensation programs and expanded program eligibility to downwind individuals, communities, and tribes affected by the ongoing environmental harms of historic atomic weapons testing, including, but not limited to, residents of areas affected by the test of the first atomic bomb in New Mexico and uranium miners employed between 1942 through 1990.

Your Reference Committee heard unanimously supportive testimony on Resolution 435. No amendments or concerns were raised. Madam Speaker, your Reference Committee recommends that Resolution 435 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(11) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 - SUPPORT REMOVAL OF BMI AS A STANDARD MEASURE IN MEDICINE AND RECOGNIZING CULTURALLY-DIVERSE AND VARIED PRESENTATIONS OF EATING DISORDERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Recommendation in CSAPH Report 3 be amended by addition and deletion to read as follows:

1. That AMA Policy H-440.797, "Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders," be amended by addition to read as follows:

1. Our American Medical Association recognizes the issues with using body mass index (BMI) as a measurement because:

a. of the historical harm of BMI;
b. of the use of BMI for racist exclusion; and
c. BMI cutoffs are based primarily on data collected from previous generations of non-Hispanic White populations and does not consider a person's gender or ethnicity.

2. Our AMA recognizes the significant limitations associated with the widespread use of BMI in clinical settings and suggests its use be in a conjunction with other valid measures of risk such as, but not limited to, measurements of:

a. visceral fat;
b. body composition;
c. waist circumference; and
d. genetic/metabolic factors.

3. Our AMA recognizes that BMI is significantly correlated with the amount of fat mass in the general population but loses predictability when applied on the individual level.

4. Our AMA recognizes that relative body shape and composition heterogeneity across race/ethnic groups, sexes, and age-span is essential to consider when applying BMI as a measure of adiposity.

5. Our AMA recognizes that the use of BMI should not be used as a sole criterion to deny appropriate insurance reimbursement.

6. Our AMA recognizes the use of BMI within the context of comorbidities, baseline mortality risk, and environmental factors such as chronic stressors, poor nutrition, and low physical activity may be used for risk stratification.

7. Our AMA recognizes BMI is a widely used tool for population level surveillance of obesity trends due to its ease of use and low risk for application inconstancies, but BMI does not fully capture the complexity of the obesity epidemic.

8. Our AMA recognizes that BMI, in combination with other anthropometric measures and environmental factors, may be useful as an initial screener to identify individuals for further investigation of health risks.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that CSAPH 3 be amended by addition of a fourth Recommendation to read as follows:

4. Our AMA advocates for coverage of evidence-based alternative measures for diagnosing obesity. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the Recommendations in CSAPH Report 3 be adopted as amended and the remainder of the report be filed.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title be changed of CSAPH Report 3 to read as follows:

SUPPORT FOR EVIDENCE-BASED USE OF BMI AS A MEASURE IN MEDICINE

HOD ACTION: Recommendations in Council on Science and Public Health Report 3 be adopted as amended with a title change and the remainder of the report be filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That AMA Policy H-440.797, "Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders," be amended by addition to read as follows:

1. Our AMA recognizes:

1. the issues with using body mass index (BMI) as a measurement because: (a) of the historical harm of BMI, (b) of the use of BMI for racist exclusion, and (c) BMI cutoffs are based primarily on data collected from previous generations of non-Hispanic White populations and does not consider a person's gender or ethnicity.

2. the significant limitations associated with the widespread use of BMI in clinical settings and suggests its use be in a conjunction with other valid measures of risk such as, but not limited to, measurements of: (a) visceral fat, (b) body adiposity index, (c) body composition, (d) relative fat mass, (e) waist circumference and (f) genetic/metabolic factors.

3. that BMI is significantly correlated with the amount of fat mass in the general population but loses predictability when applied on the individual level.

4. that relative body shape and composition heterogeneity across race/ethnic groups, sexes, and age-span is essential to consider when applying BMI as a measure of adiposity.

5. that the use of BMI should not be used as a sole criterion to deny appropriate insurance reimbursement.

6. the use of BMI within the context of comorbidities, baseline mortality risk, and environmental factors such as chronic stressors, poor nutrition, and low physical activity may be used for risk stratification.

7. BMI is a widely used tool for population level surveillance of obesity trends due to its ease of use and low risk for application inconstancies, but BMI does not fully capture the complexity of the obesity epidemic.

8. that BMI, in combination with other anthropometric measures and environmental factors, may be useful as an initial screener to identify individuals for further investigation of metabolic health risks.

2. Our AMA supports further research on the application of the extended BMI percentiles and z-scores and its association with other anthropometric measurements, risk factors, and health outcomes.

3. Our AMA supports efforts to educate physicians on the issues with BMI and alternative measures for diagnosing obesity. (Amend HOD Policy)

Your Reference Committee heard mostly supportive testimony on this item. Supportive testimony noted that BMI has many shortcomings as a measure of health risk and that

studies show that physical fitness and nutritional status better predict overall health and mortality risk. An amendment was proffered to change the title to better capture the content of the report as well as the current policy. Your Reference Committee agrees with this amendment to the title. An amendment was proffered to remove body adiposity index and relative fat mass because these are not widely accepted tools. Your Reference Committee agrees with this amendment. Further, another amendment was proffered to include other measures of obesity such as DEXA and bioelectrical impedance noting that these tools are not covered by insurance. There was testimony in opposition of specific inclusion of measures. Your Reference Committee agrees with this but also supports the need to have insurance coverage of new tools to measure obesity and has therefore recommended the inclusion of “evidence-based tools” to alleviate this concern. Testimony in opposition noted that BMI is a useful risk factor for obstructive sleep apnea. Your Reference Committee would like to note that the CSAPH recommendations support BMI in the context of other factors for risk stratification and therefore address the concern for use of BMI in the context of obstructive sleep apnea. Testimony in opposition also noted the need to make sure that obesity measures are validated in children. Your Reference Committee would like to note that this was discussed in the original BMI report presented at A-23 and is not germane to the body of this report. Therefore, Madam Speaker, your Reference Committee recommends that Recommendations in Council on Science and Public Health Report 3 be adopted as amended.

(12) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 6 – GREENHOUSE GAS EMISSIONS FROM METERED DOSE INHALERS AND ANESTHETIC GASES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Recommendation in CSAPH Report 6 be amended by addition to read as follows:

2. That Policy H-135.913, "Metered Dose Inhalers and Greenhouse Gas Emissions" be amended by addition and deletion to read as follows:

1. Our American Medical Association will advocate to reduce the climate effects of hydrofluorocarbon propellants in metered-dose inhalers and encourage strategies supporting the development and use of alternative inhalers and propellants with equal and or higher efficacy and less adverse effect on our climate.
2. Our AMA supports legislative and regulatory reforms that increase access to affordable inhalers with lower greenhouse gas emissions that align with current recommended standards of care. Reforms should aim to ensure the quality of patents issued on new drug-device combinations, prevent new patents for minor changes made to delivery systems, and remove barriers to market entry for generic inhalers.
3. Our AMA supports consideration of the environmental impacts of inhalers when creating prescription drug formularies and for the federal government to factor environmental impact into price negotiations with pharmaceutical manufacturers.
4. Our AMA recognizes the unique role metered dose inhalers play, in combination with spacers and facemasks, in treating vulnerable patients who are unable to use other inhaler options due to age, physiologic limitation from weakness or neurocognitive limitations, including but not limited to children with asthma, patients with tracheostomies, patients with cerebrovascular injuries, and patients with neuromuscular diseases.
~~3. Our AMA will study options for reducing hydrofluorocarbon use in the medical sector.~~ (Modify Current AMA Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Recommendation in CSAPH Report 6 be amended by deletion to read as follows:

3. That the following new policy be adopted.

Reducing Environmental Impacts of Anesthetic Gases

Our American Medical Association, in collaboration with interested parties and organizations, will disseminate evidence-based content and recommended strategies to reduce the global warming impact of anesthetic gases. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that CSAPH Report 6 be adopted as amended and the rest of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 6 be adopted as amended and the remainder of the report be filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That Policy H-160.932, "Asthma Control" be amended by addition and deletion to read as follows:

The AMA: (1) encourages physicians to make appropriate use of evidence-based guidelines, including those contained in ~~Expert Panel Report III: Guidelines for the Diagnosis and Management of Asthma released by the National Heart, Lung and Blood Institute and~~ the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group 2020 Focused Updates to the Asthma Management Guidelines; (2) encourages physicians to provide self-management education tailored to the literacy level of the patient by teaching and reinforcing appropriate self-monitoring, the use of a written asthma action plan, taking medication correctly, and avoiding environmental factors that worsen asthma; ~~and~~ (3) encourages physicians to incorporate the four components of care (assessment and monitoring; education; control of environmental factors and comorbid conditions; and appropriate medication selection and use)~~.~~; and (4) will, in collaboration with interested parties and organizations, develop content to help physicians talk through the different asthma control options and their known economic costs and environmental impacts. (Modify Current AMA Policy)

2. That Policy H-135.913, "Metered Dose Inhalers and Greenhouse Gas Emissions" be amended by addition and deletion to read as follows:

1. Our AMA will advocate to reduce the climate effects of hydrofluorocarbon propellants in metered-dose inhalers and encourage strategies ~~for encouraging~~

supporting the development and use of alternative inhalers and propellants with equal and or higher efficacy and less adverse effect on our climate.

2. Our AMA ~~will advocate for~~ supports legislative and regulatory reforms~~,~~ that increase access to affordable ~~to keep~~ inhalers ~~medications affordable and accessible, will urge FDA to consider metered-dose inhaler propellant substitutions for the purposes of climate protection as drug reclassifications,~~ with lower greenhouse gas emissions that align with current recommended standards of care. Reforms should aim to ensure the quality of patents issued on new drug-device combinations, prevent new patents for minor changes made to delivery systems, and remove barriers to market entry for generic inhalers.

3. Our AMA supports consideration of the environmental impacts of inhalers when creating prescription drug formularies and for the federal government to factor environmental impact into price negotiations with pharmaceutical manufacturers. ~~without new patent or exclusivity privileges, and not allow these substitutions to classify as new drug applications.~~

~~3. Our AMA will study options for reducing hydrofluorocarbon use in the medical sector~~. (Modify Current AMA Policy)

3. That the following new policy be adopted.

Reducing Environmental Impacts of Anesthetic Gases

The AMA, in collaboration with interested parties and organizations, will disseminate evidence-based content and recommended strategies to reduce the global warming impact of anesthetic gases and encourage the phasing out of desflurane as an anesthetic gas. (New HOD Policy)

Your Reference Committee heard generally supportive testimony on CSAPH Report 6, particularly regarding the first and second Recommendations, with an amendment proffered to address the unique role that metered dose inhalers play in some populations that are unable to use other inhaler options. The suggested amendment was supported by others testifying. Your committee also heard testimony from delegations representing anesthesiologists that were not in support of the third recommendation because of its call to phase out desflurane, even though it was noted by others that many health systems have already started eliminating the use of desflurane and that there are cost savings from its removal. One individual, while supportive of the report, was wondering why we should be concerned about the greenhouse gas emissions from inhalers when Taylor Swift frequently takes private international jet trips. Your Reference Committee felt the proffered amendment on the utility of metered dose inhaler for use in specific populations was relevant to include but did not feel that the complete removal of the third recommendation was warranted, as most of the recommendation language supports engagement with interested parties on disseminating evidence-based content and recommended strategies. However, your Reference Committee supported the removal of specific language about desflurane in attempt to not limit other anesthetic gases that might contribute to climate change. Madam Speaker, your Reference Committee recommends that recommendations in Council on Science and Public Health Report 6 be adopted as amended.

(13) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 9 – PRESCRIBING GUIDED PHYSICAL ACTIVITY FOR DEPRESSION AND ANXIETY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Recommendation in CSAPH Report 9 be amended by deletion to read as follows:

1. That our AMA amend policy H-470.997, "Exercise and Physical Fitness" by addition and deletion to read as follows:

Exercise and Physical Fitness H-470.997
1. Our AMA encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation and urges state and local medical societies to emphasize through all available channels the need for physical activity ~~for all age groups and both sexes~~. The AMA encourages other organizations and agencies to join ~~with the Association~~ in promoting physical fitness through all appropriate means.

~~Our AMA will study evidence of the efficacy of physical activity interventions (i.e., group fitness, personal training, or physical therapy) on behavioral activation and outcomes on depressive and anxiety symptoms.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Recommendation in CSAPH Report 9 be amended by addition and deletion to read as follows:

3. Our AMA encourages:

1. the education of health care professionals on the role of physical activity and/or structured exercise in treating and managing anxiety and depression; ~~and~~ the need to screen for levels of physical activity of patients; ~~,~~ the need to motivate~~,~~ and educate patients of all ages about the benefits of physical activity, including positive mental health benefits.

2. the provision of coverage by health care payers and employers ~~to provide coverage~~ for ~~gym~~ fitness club memberships and access to other physical activity programs.

3. the implementation, trending, and utilization of evidenced-based physical activity measures~~, such~~

~~as physical activity vital signs (PAVS),~~ in the medical record for treatment prescription, counseling, coaching, and follow up of physical activity for therapeutic use. (Modify HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the Recommendations in CSAPH Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 9 be adopted as amended and the remainder of the report be filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That our AMA amend policy H-470.997, "Exercise and Physical Fitness" by addition and deletion to read as follows:

Exercise and Physical Fitness H-470.997
1. Our AMA encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation and urges state and local medical societies to emphasize through all available channels the need for physical activity for all age groups and both sexes. The AMA encourages other organizations and agencies to join with the Association in promoting physical fitness through all appropriate means.

~~Our AMA will study evidence of the efficacy of physical activity interventions (i.e., group fitness, personal training, or physical therapy) on behavioral activation and outcomes on depressive and anxiety symptoms.~~

2. Our AMA advocates for continued research towards development of structured physical activity treatment plans for the specific diagnoses of anxiety and depression, as well as longitudinal studies to examine the effects of physical activity on health outcomes, particularly later in life.

3. Our AMA encourages:
1. education of health care professionals on the role of physical activity and/or structured exercise in treating and managing anxiety and depression and the need to screen, motivate, and educate patients of all ages about the benefits of physical activity, including positive mental health benefits.
2. health care payers and employers to provide coverage for gym memberships and access to other physical activity programs.
3. the implementation, trending, and utilization of physical activity measures, such as physical activity vital signs (PAVS), in the medical record for treatment prescription, counseling, coaching, and follow up of physical activity for therapeutic use. (Modify HOD Policy)

Your Reference Committee heard supportive testimony on this report. The testimony noted that physical activity is important for health and function, and not just physical but also mental and emotional wellbeing. However, a few amendments were proffered on the report recommendations. In particular, there was concern with the inclusion of the physical activity vital signs (PAVS) in the recommendation, as it was noted that there is no evidence to support the inclusion of that measure. Those testifying also noted they wanted to avoid unnecessary administrative burden to physicians and staff. The report authors offered rebuttal testimony noting that PAVS is just one example of a measure that can be used to track progress as a therapy when physical activity is prescribed, not as something that needs to be documented all the time. Your Reference Committee felt the inclusion of the PAVS specific language was unnecessary and opted to include language around evidence-based physical activity measures. Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 9 be adopted as amended.

(14) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 13 - DECREASING YOUTH ACCESS TO E-CIGARETTES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Recommendation in CSAPH Report 13 be amended by addition and deletion to read as follows:

(10) supports measures that decrease the geographic density of tobacco retail stores, including but not limited to, preventing retailers from selling tobacco products in stores in close proximity to schools. (Modify Current AMA Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendations in CSAPH Report 13 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 13 be adopted as amended and the remainder of the report be filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA supports the inclusion of all forms of e-cigarettes (e.g., disposable, refillable cartridge, and tank-based e-cigarettes) in the language and implementation of relevant nicotine-based policies and regulations by the Food and Drug Administration or other regulatory agencies. (New HOD Policy)

2. That current AMA Policy H-495.986, “Tobacco Product Sales and Distribution,” be amended by addition to read as follows:

Tobacco Product Sales and Distribution, H-495.986
(1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
(2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
(3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
(4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
(5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
(7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
(8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and
(9) opposes the sale of tobacco at any facility where health services are provided; and
(10) supports measures that decrease the overall density of tobacco specialty stores, including but not limited to, preventing retailers from opening new tobacco specialty stores in close proximity to schools. (Modify Current AMA Policy)

3. That our AMA reaffirm Policies H-495.970, “Regulation of “Cool/Non-Menthol” Tobacco Products, H-495.971 “Opposition to Addition of Flavors to Tobacco Products,” and H-495.976, “Opposition to Exempting the Addition of Menthol to Cigarettes.” (Reaffirm HOD Policy)

Your Reference Committee heard mostly supportive testimony on the recommendations in the Council of Science and Public Health Report 13. Two delegations proffered minor amendments to the language of Recommendation two, subclause 10. Specifically, one delegation supported removing language regarding specialty stores, noting that e-cigarettes are primarily purchased at gas stations and convenience stores therefore more inclusive language would be more appropriate. Although there were concerns about the feasibility of decreasing geographic density by one delegation, there was general support for this recommendation and the proposed amendments. Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 13 be adopted as amended.

(15) RESOLUTION 403 – OCCUPATIONAL SCREENINGS FOR LUNG DISEASE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 403 be <u>amended by deletion</u> to read as follows:

RESOLVED, that our AMA amend Policy H-365.988, "Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies" by addition and deletion as follows:

1. Our American Medical Association supports the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level.
2. Our AMA supports taking a leadership role in assisting state medical societies in implementation of such programs.
3. Our AMA supports working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy.
4. Our AMA recognizes barriers to accessibility and utilization of such programs.
5. Our AMA recognizes inequities in occupational health screenings for pulmonary disease and supports efforts to increase accessibility of these screenings.
6. Our AMA encourages utilization of free and accessible screenings, such as those used in the NIOSH Coal Workers Health Surveillance Program, for other at-risk occupational groups.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 403 be <u>adopted as amended</u>.

HOD ACTION: Resolution 403 be adopted as amended.

RESOLVED, that our AMA amend Policy H-365.988, "Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies" by addition and deletion as follows:

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

Your Reference Committee heard generally supportive testimony on this resolution, with small editorial amendments proffered which were supported by the resolution authors. Testimony acknowledged the importance of the issue for many living in medically underserved and marginalized communities. Testimony noted that the modified policy could help reduce barriers to occupational health services while another person noted that the issue is not with access but rather that miners are being disincentivized from getting screened. However, no amendments were proffered to address this last concern. Madam Speaker, your Reference Committee recommends that Resolution 403 be adopted as amended.

(16) RESOLUTION 406 – OPPOSITION TO PAY-TO-STAY INCARCERATION FEES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 406 be amended by addition and deletion to read as follows:

1. Our American Medical Association oppose fees charged to justice involved individuals for room and board and advocate for federal and state efforts to repeal statutes and ordinances which permit inmates to be charged for room and board and basic amenities.

2. Our AMA oppose probation and parole supervision fees and support federal and state efforts to repeal statutes and ordinances which permit individuals on probation or parole to be charged for supervision fees.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 406 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title be changed of Resolution 406 to read as follows:

OPPOSITION TO JUSTICE INVOLVED FEES

HOD ACTION: Resolution 403 be adopted as amended with a title change.

RESOLVED, that our American Medical Association oppose fees charged to incarcerated individuals for room and board and advocate for federal and state efforts to repeal statutes and ordinances which permit inmates to be charged for room and board. (Directive to Take Action)

Your Reference Committee heard supportive testimony of this resolution highlighting the detrimental effects of pay-to-stay prison requirements on both individuals and society and the need to find alternative approaches. An amendment was proffered to use the terminology justice involved instead of incarcerated individuals, noting that these labels are dehumanizing and increases stigmatization. Another amendment was proffered to include supervision fees noting that they have the same detrimental effects as pay-to-stay fees. The author and your Reference Committee agree with this inclusion given it falls within the scope of this resolution. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 406 be adopted as amended.

(17) RESOLUTION 407 – RACIAL MISCLASSIFICATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 407 be amended by addition to read as follows:

4. Our AMA further supports HIPAA-compliant, Tribally approved data linkages between Native Hawaiian and Tribal Registries, population-based and hospital-based clinical trial and disease registries, and local, state, tribal, and federal vital statistics databases aimed at minimizing racial misclassification.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 407 be adopted as amended.

HOD ACTION: Resolution 407 be adopted as amended.

RESOLVED, that our American Medical Association amend H-85.953, "Improving Death Certification Accuracy and Completion," by addition as follows:

Improving Death Certification Accuracy and Completion H-85.953
1. Our AMA: (a) acknowledges that the reporting of vital events is an integral part of patient care; (b) urges physicians to ensure completion of all state vital records carefully and thoroughly with special attention to the use of standard nomenclature, using legible writing and accurate diagnoses; and (c) supports notifying state medical societies and state departments of vital statistics of this policy and encouraging their assistance and cooperation in implementing it.
2. Our AMA also: (a) supports the position that efforts to improve cause of death statistics are indicated and necessary; (b) endorses the concept that educational efforts to improve death certificates should be focused on physicians, particularly those who take care of patients in facilities where patients are likely to die, namely in acute hospitals, nursing homes and hospices; and (c) supports the concept that training sessions in completion of death certificates should be (i) included in hospital house staff orientation sessions and clinical pathologic conferences; (ii) integrated into continuing medical education presentations; (iii) mandatory in mortality conferences; and (iv) included as part of in-service training programs for nursing homes, hospices and geriatric physicians.
3. Our AMA further: (a) promotes and encourages the use of ICD codes among physicians as they complete medical claims, hospital discharge summaries, death certificates, and other documents; (b) supports cooperating with the National Center for Health Statistics (NCHS) in monitoring the four existing models for collecting tobacco-use data; (c) urges the NCHS to identify appropriate definitions, categories, and methods of collecting risk-factor data, including quantification of exposure, for inclusion on the U.S. Standard Certificates, and that subsequent data be appropriately disseminated; and (d) continues to encourage all physicians to report tobacco use, exposure to environmental tobacco smoke, and other risk factors using the current standard death certificate format.
4. Our AMA further supports HIPAA-compliant data linkages between Native Hawaiian and Tribal Registries, population-based and hospital-based clinical trial and disease registries, and local, state, tribal, and federal vital statistics databases aimed at minimizing racial misclassification. (Modify HOD Policy)

Your Reference Committee heard mostly supportive testimony on Resolution 407. Testimony highlighted the potential to reduce disparities by improving vital statistics, which currently are plagued by missing and inaccurate information. An amendment was proffered to expand the language in the fourth resolve clause to specify that the HIPAA-compliant data linkages also be Tribally approved. Multiple delegations supported the amendment as written. Madam Speaker, your Reference Committee recommends that Resolution 407 be adopted as amended.

(18) RESOLUTION 409 – TOXIC HEAVY METALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 409 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support efforts: (a) to monitor ~~and educate individuals on (a)~~ the chronic effects of exposure to ~~toxic~~ hazardous pollutants and heavy metals including at levels below regulation limits, ~~and~~ (b) to monitor the burden of toxicity in communities, especially near urban, Superfund, military bases, and industrial sites, and (c) to educate individuals on the chronic effects of those exposures. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 409 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title be changed of Resolution 409 to read as follows:

HAZARDOUS POLLUTANTS AND HEAVY METALS

HOD ACTION: Resolution 409 be adopted as amended with a title change.

RESOLVED, that our American Medical Association urge governmental agencies to establish and enforce limits for identified hazardous pollutants and heavy metals in our food, water, soil, and air (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to monitor and educate individuals on (a) the chronic effects of exposure to toxic heavy metals including at levels below regulation limits, and (b) the burden of toxicity in communities, especially near urban, Superfund, and industrial sites. (New HOD Policy)

Testimony on this resolution was mostly supportive. The authors as well as others testifying noted the well-known negative health effects of hazardous pollutants and heavy metals, which are disproportionately high among urban communities that fall within historically redlined areas, and the lack of existing regulatory standards for some of these toxic substances. Several delegations proffered minor amendments to the title and resolution text to be consistent in language and to add military bases as a community that is disproportionally impacted by exposure to hazardous pollutants and heavy metals. Your Reference Committee was supportive of these minor changes. Madam Speaker, your Reference Committee recommends that Resolution 409 be adopted as amended and that the title be changed.

(19) RESOLUTION 410 – ACCESS TO PUBLIC RESTROOMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 410 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, that our AMA supports <u>equity</u> in restroom access by gender identity, including increasing the number of female and gender-neutral bathrooms available in both new and existing buildings.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 410 be <u>adopted as amended</u>.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the <u>title be changed</u> of Resolution 410 to read as follows:

EQUITY IN ACCESS TO PUBLIC RESTROOMS

HOD ACTION: Resolution 410 be <u>adopted as amended</u>.

RESOLVED, that our American Medical Association support access to clean, accessible, and permanent public restrooms that, at minimum, contain a toilet and sink, regardless of any identifying characteristics such as gender identity, appearance, employment status, or commercial status (New HOD Policy); and be it further

RESOLVED, that our AMA support parity in restroom access by gender identity, including increasing the number of female and gender-neutral bathrooms available in both new and existing buildings. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony on Resolution 410. An amendment was proffered to replace parity with equity in the second resolve, which was also supported. The title revision ensures alignment between the policy and the title. Madam Speaker, your Reference Committee recommends that Resolution 410 be adopted as amended.

(20) RESOLUTION 411 – MISSING AND MURDERED INDIGENOUS PERSONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 411 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association supports emergency alert systems for American Indian and Alaska Native tribal members reported missing on tribal reservations and elsewhere. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 411 be adopted as amended.

HOD ACTION: Resolution 411 be adopted as amended.

RESOLVED, that our American Medical Association supports emergency alert systems for American Indian and Alaska Native tribal members reported missing on reservations and in urban areas. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony on Resolution 411. In particular, multiple delegations highlighted the success of existing state specific systems. Amendments were proffered by two delegations to create broader and more inclusive language about where the policy would apply. The amendments highlight the need to include individuals reported missing both on tribal reservations and elsewhere, rather than limiting it to only tribal lands and urban areas. These amendments were supported by multiple delegations. Madam Speaker, your Reference Committee recommends that Resolution 411 be adopted as amended.

(21) RESOLUTION 412 – LITHIUM BATTERY SAFETY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 412 be amended by addition and deletion to read as follows:

1. Our American Medical Association supports legislation to increase environmental and public safety oversight of lithium batteries and businesses that store and dispose of lithium batteries.

2. Our AMA supports educational efforts to inform the public about the proper disposal and recycling of lithium batteries and the risks of improper storage and disposal of lithium batteries.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 412 be adopted as amended.

HOD ACTION: Resolution 412 be adopted as amended.

RESOLVED, that our American Medical Association seek legislation to increase environmental and public safety oversight of lithium batteries and businesses that store and dispose of lithium batteries. (Directive to Take Action)

Your Reference Committee heard testimony in support of this resolution, citing serious fire safety concerns from the explosion of lithium batteries. An additional resolve clause was proffered to support education efforts on this topic, which was supported by the resolution authors. Your Reference Committee supports the adoption of this resolution and believes the proffered amendment and additional resolve clause makes this an even stronger policy. Madam Speaker, your Reference Committee recommends that Resolution 412 be adopted as amended.

(22) RESOLUTION 416 – FURTHERING ENVIRONMENTAL JUSTICE AND EQUITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 416 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or that have been impacted by other discriminatory development and building practices~~,~~ ~~thereby protecting residents of these communities from displacement~~ with full participation by the community residents in these decisions. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 416 be adopted as amended.

HOD ACTION: Resolution 416 be adopted as amended.

RESOLVED, that our American Medical Association support state and local climate-health risk assessments, disease surveillance and early warning systems, and research on climate and health, with actions to improve and/or correct the findings (New HOD Policy); and be it further

RESOLVED, that our AMA support measures to protect frontline communities from the health harms of proximity to fossil fuel extraction, refining and combustion, such as the best available technology to reduce local pollution exposure from oil refineries, or health safety buffers from oil extraction operations (New HOD Policy); and be it further

RESOLVED, that our AMA support prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or that have been impacted by other discriminatory development and building practice, thereby protecting residents of these communities from displacement. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony on this resolution, with an amendment proffered on the third resolve to be aligned with AMA's current environmental justice policy. Resolution authors testified they were supportive of the suggested amendment. Testimony noted the inequitable distribution of risks from climate change and environmental-related threats among vulnerable communities and the role that redlining and other historically racist policies contribute to these existing health disparities. Your Reference Committee agreed with the provided testimony and proffered amendment. Madam Speaker, your Reference Committee recommends that Resolution 416 be adopted as amended.

(23) RESOLUTION 420 – EQUITY IN DIALYSIS CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 420 be <u>amended by addition</u> of two Resolve clauses to read as follows:

<u>RESOLVED, that our American Medical Association ask the Indian Health Service to offer a plan, agency expertise, technical assistance, and health-facilities funding to assist Tribes in expanding local dialysis services; and be it further</u>

<u>RESOLVED, that our AMA support a nationwide American Indian and Alaskan Native Medicare and Medicaid enrollment campaign coordinated by CMS and the IHS that funds insurance navigator programs at Tribal Health Programs to improve equitable access to dialysis care</u>.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 420 be <u>adopted as amended</u>.

HOD ACTION: Resolution 420 be <u>adopted as amended</u>.

RESOLVED, that our American Medical Association declare kidney failure as a significant public health problem with disproportionate affects and harm to under-represented communities (New HOD Policy); and be it further

RESOLVED, that our AMA vigorously pursue potential solutions and partnerships to identify economic, cultural, clinical and technological solutions that increase equitable access to all modalities of care including home dialysis. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony on Resolution 420. An amendment was proffered adding two resolve clauses; specifically, that the Indian Health Service both provide guidance and technical expertise as well as funding these efforts in collaboration with CMS. Madam Speaker, your Reference Committee recommends that Resolution 420 be adopted as amended.

(24) RESOLUTION 422 – IMMUNIZATION REGISTRY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first and third Resolves of Resolution 422 be deleted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 422 be adopted as amended.

HOD ACTION: Resolution 422 be adopted as amended.

RESOLVED, that our American Medical Association develop model legislation requiring all vaccine providers to participate in their statewide immunization information system (Directive to Take Action); and be it further

RESOLVED, that our AMA support mandating all vaccine providers to report all immunizations to their respective state immunization registry, for both adults and children (New HOD Policy); and be it further

RESOLVED, that our AMA support reimbursement for reporting immunizations to state registries by both public and private payers.(New HOD Policy)

Your Reference Committee heard supportive testimony noting that non-physician entities administer vaccines, and it is crucial to have access to up-to-date immunization records. Supportive testimony also noted that this aligns adult vaccinations with pediatric vaccinations so that reporting is consistent. Testimony also noted that reimbursement is may not as much of an issue once the interface is established with the state due to automatic reporting and therefore recommended deletion of the third Resolve clause. Your Reference Committee agrees with this amendment. Further, testimony noted most states already have legislation establishing statewide immunization information systems and therefore the first Resolve clause asking for the development of model legislation isn't

necessary. Your Reference Committee agrees. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 422 be adopted as amended.

(25) RESOLUTION 424 – LGBTQ+ SENIOR HEALTH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 424 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~create and~~ disseminate educational ~~initiatives~~ content to increase awareness and understanding of ~~senior~~ LGBTQ+ health aging issues among the general public, healthcare professionals, and policy makers (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 424 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~develop and~~ promote cultural competency training for clinicians in caring for ~~senior~~ LGBTQ+ older adults ~~individuals~~ (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 424 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~develop and~~ promote policies and practices for implementation within all healthcare settings that are inclusive and affirming for LGBTQ+ ~~seniors~~ older adults (Directive to Take Action); and be it further

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 424 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate for increased funding and resources for research into health issues of LGBTQ+ ~~seniors~~ older adults. (Directive to Take Action)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title be changed of Resolution 424 to read as follows:

LGBTQ+ OLDER ADULTS

HOD ACTION: Resolution 424 be adopted as amended with a title change.

RESOLVED, that our American Medical Association create and disseminate educational initiatives to increase awareness and understanding of senior LGBTQ+ health aging issues among the general public, healthcare professionals, and policy makers (Directive to Take Action); and be it further

RESOLVED, that our AMA develop and promote cultural competency training for clinicians in caring for senior LGBTQ+ individuals (Directive to Take Action); and be it further

RESOLVED, that our AMA develop and promote policies and practices for implementation within all healthcare settings that are inclusive and affirming for LGBTQ+ seniors (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased funding and resources for research into health issues of LGBTQ+ seniors. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony on Resolution 424. An amendment to terminology was proposed -- that “Senior” be changed to “Older Adult” to align with existing AMA policy. The same delegation also proposed deleting language around the creation and development of educational materials, trainings, and policies and practices in response to concerns about the fiscal note and acknowledgement that such resources exist elsewhere. Madam Speaker, your Reference Committee recommends that Resolution 424 be adopted as amended.

(26) RESOLUTION 425 – PERINATAL MENTAL HEALTH DISORDERS AMONG MEDICAL STUDENTS AND PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 425 be amended by addition and deletion to read as follows:

1. Our American Medical Association will work with relevant stakeholders to identify ways to increase screening and referrals to services for perinatal mental health conditions, including substance use disorder, with privacy protections, among medical students, physicians, and their families and reduce stigma surrounding the diagnosis and treatment of

perinatal mental health conditions, including substance use disorder, with privacy protections.

2. Our AMA will advocate for reducing structural and systemic barriers to the diagnosis and treatment of perinatal mental health conditions, including substance use disorder, with privacy protections, in physicians, medical students, and their families.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 425 be <u>adopted as amended</u>.

HOD ACTION: Resolution 425 be <u>adopted as amended</u>.

RESOLVED, that our American Medical Association work with relevant stakeholders to identify ways to increase screening for perinatal mental health conditions and reduce stigma surrounding the diagnosis and treatment of perinatal mental health conditions (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for reducing structural and systemic barriers to the diagnosis and treatment of perinatal mental health conditions in physicians and medical students.(Directive to Take Action)

Your Reference Committee heard limited, but supportive testimony on this resolution. One proposed amendment suggested expanding it beyond screening to also include referral to services. Your Reference Committee agreed that would strengthen the policy. Another amendment suggested adding reference to substance use disorders. The original authors spoke in opposition to that amendment. Your Reference Committee agrees as mental health is broad enough to encompass substance use disorders. Furthermore, given the focus on physicians and medical students, your Reference Committee did not include a proposed amendment to include reference to families of physicians and medical students as it was felt to be outside of the scope. Therefore, your Reference Committee recommends that Resolution 425 be adopted as amended.

(27) RESOLUTION 428 – ADVOCATING FOR EDUCATION AND ACTION REGARDING THE HEALTH HAZARDS OF PFAS CHEMICALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 428 be <u>amended by addition and deletion</u> to read as follows:

Our American Medical Association will <u>amplify</u> physician and public education around the adverse health effects of PFAS <u>chemicals</u> and potential

mitigation and prevention efforts. (Directive to Take Action).

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 428 be adopted as amended.

HOD ACTION: Resolution 428 be adopted as amended.

RESOLVED, that our American Medical Association improve physician and public education around the adverse health effects of PFAS and potential mitigation and prevention efforts. (Directive to Take Action).

Your Reference Committee heard testimony that was generally supportive, noting that PFAS chemicals have harmful impacts on the endocrine system have a ubiquitous presence in our environment, and that there are no known safe limits for PFAS. Testimony acknowledged that this issue was timely, as physicians are increasingly being called upon to address this issue with their patients. Online testimony noted that there is existing educational content that AMA could amplify, as opposed to developing new content itself. Based on this testimony, the Reference Committee believes a small modification to the proposed resolution text would address proffered testimony. Madam Speaker, your Reference Committee recommends that Resolution 428 be adopted as amended.

(28) RESOLUTION 430 – SUPPORTING THE INCLUSION OF INFORMATION ABOUT LUNG CANCER SCREENING WITHIN CIGARETTE PACKAGES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 430 be referred for decision.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 430 be amended by addition and deletion to read as follows:

Our American Medical Association will work with appropriate public health organizations and governmental agencies to monitor the impact of novel nicotine delivery devices on cancer epidemiology and promote appropriate cancer screening should the suspected link be proven.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 430 be <u>adopted as amended</u>.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the <u>title be changed</u> of Resolution 430 to read as follows:

CANCER RISKS ASSSOCIATED WITH NOVEL NICOTINE DELIVERY DEVICES

HOD ACTION: Resolution 430 be <u>adopted as amended</u> with a <u>change in title</u>.

RESOLVED, that our American Medical Association advocate for information about lung cancer screening to be included within all combustible tobacco product packaging (Directive to Take Action); and be it further

RESOLVED, that our AMA will work with appropriate public health organizations and governmental agencies to monitor the impact of "non-combustible tobacco" nicotine delivery devices on cancer epidemiology and promote appropriate cancer screening should the suspected link be proven. (Directive to Take Action)

Your Reference Committee heard mixed testimony on this resolution. While there is agreement that lung cancer screening rates should be improved, there was conflicting testimony as to whether the first Resolve was the best way to accomplish that. Those in support argued that this is currently within the FDA's purview. Others cautioned that there is no evidence to suggest that including information about lung screening on tobacco products would improve screening rates. It was also stated that this approach would require opening up the Tobacco Control Act and could weaken that law. Your Reference Committee thinks this is complex and recommends the first Resolve be referred for decision. The second Resolve was generally supported with amendments to broaden it beyond "non-combustible tobacco." Your Reference Committee agrees that expanding this resolve to cover all novel nicotine products is advisable and therefore recommends adoption as amended with a change in title to ensure alignment in scope.

(29) RESOLUTION 432 – RESOLUTION TO DECREASE LEAD EXPOSURE IN URBAN AREAS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that <u>the second Resolve</u> of Resolution 432 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, that our AMA advocates for accessible testing of domestic water supplies, prioritizing testing for lead in potable water used by pregnant ~~women~~ <u>people</u>, newborns and young children, <u>and</u> with the

provision of accessible water filters in homes found to have elevated lead levels in potable water (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends Resolution 432 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title be changed of Resolution 432 to read as follows:

DECREASING LEAD EXPOSURE

HOD ACTION: Resolution 432 be adopted as amended with a change in title.
¶

RESOLVED, that our American Medical Association reaffirm the following policy H-135.928, "Safe Drinking Water" in support of EPA's Lead and Copper Rule and evidence-based research demonstrating there is no safe level of lead for humans and therefore warrants immediate Federal, State, and municipal action (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA advocates for accessible testing of domestic water supplies, prioritizing testing for lead in potable water used by pregnant ~~women~~ people, newborns and young children, and with the provision of accessible water filters in homes found to have elevated lead levels in potable water

RESOLVED, that our AMA supports increased funding for lead pipe replacement and other steps to eliminate lead from public and private drinking water supplies (Directive to Take Action); and be it further

RESOLVED, that our AMA promotes community awareness and education campaigns on the causes and risks of lead in drinking water and steps that can be taken to eliminate these risks (Directive to Take Action); and be it further

RESOLVED, that our AMA supports the development and use of searchable registries of housing units known to have unresolved lead in the drinking water due to lead connectors to water mains or other sources of lead in the drinking water in cities with significant public lead exposure (Directive to Take Action); and be it further

RESOLVED, that our AMA urges healthcare providers to increase screening for lead exposure, particularly in areas known to have lead pipes, and particularly in underserved areas (Directive to Take Action); and be it further

RESOLVED, that our AMA calls for research into innovative and cost-effective methods for elimination of lead in public and private water supplies and lead from lead pipe connectors to such water supplies (Directive to Take Action).

Your Reference Committee heard mostly supportive testimony. Resolution authors and others testified that despite improvements in lead exposure over the past few decades, it remains a concern, particularly among young children in historically marginalized communities. Two amendments were proffered; one to align language around individuals who are pregnant to preferred terminology and the other to remove the reference to urban areas in the title, as lead exposure in drinking water is a concern in rural communities. The Reference Committee agreed these minor changes were relevant and therefore, Madam Speaker, your Reference Committee recommends that Resolution 432 be adopted as amended.

(30) RESOLUTION 433 – IMPROVING HEALTHCARE OF RURAL MINORITY POPULATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 433 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association encourage health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to ~~rural minorities~~ minority communities in rural areas (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 433 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourage enhanced understanding by federal, state and local governments of the unique health and health-related needs, including mental health, of ~~rural minorities~~ minority communities in rural areas in an effort to improve their quality of life; (New HOD Policy) and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 433 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA encourage the collection of vital statistics and other relevant demographic data of ~~rural minorities~~ minority communities in rural areas (New HOD Policy); and be it further

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 433 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~encourage~~ advise organizations of the importance of ~~rural~~ minority health in rural areas (New HOD Policy); and be it further

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the fifth Resolve of Resolution 433 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA research and study health issues unique to ~~rural minorities~~ minority communities in rural areas, such as access to care difficulties (Directive to Take Action); and be it further

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that the sixth Resolve of Resolution 433 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA channel existing policy for telehealth to support ~~rural~~ minority communities in rural areas (Directive to Take Action); and be it further

RECOMMENDATION G:

Madam Speaker, your Reference Committee recommends that the seventh Resolve of Resolution 433 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA will encourage our Center for Health Equity to support ~~rural~~ minority health in rural areas through programming, equity initiatives, and other representation efforts. (New HOD Policy)

RECOMMENDATION H:

Madam Speaker, your Reference Committee recommends that Resolution 433 be adopted as amended.

RECOMMENDATION I:

Madam Speaker, your Reference Committee recommends that the title be changed of Resolution 433 to read as follows:

IMPROVING HEALTHCARE OF MINORITY COMMUNITIES IN RURAL AREAS

HOD ACTION: Resolution 433 be adopted as amended with a change in title.

RESOLVED, that our American Medical Association encourage health promotion, access to care, and disease prevention through educational efforts and publications specifically tailored to rural minorities (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage federal, state and local governments of the unique health and health-related needs of rural minorities in an effort to improve their quality of life; (New HOD Policy) and be it further

RESOLVED, that our AMA encourage the collection of vital statistics and other relevant demographic data of rural minorities (New HOD Policy); and be it further

RESOLVED, that our AMA encourage organizations of the importance of rural minority health (New HOD Policy); and be it further

RESOLVED, that our AMA research and study health issues unique to rural minorities, such as access to care difficulties (Directive to Take Action); and be it further

RESOLVED, that our AMA channel existing policy for telehealth to support rural minority communities (Directive to Take Action); and be it further

RESOLVED, that our AMA will encourage our Center for Health Equity to support rural minority health through programming, equity initiatives, and other representation efforts. (New HOD Policy)

Your Reference Committee heard testimony mostly in support of this resolution and praise for bringing this issue to the forefront. There were some questions as to which minority populations were specifically included as rural minorities. Your Reference Committee believed it was best to not list specific groups, but to clarify the language throughout by changing it from “rural minorities” to “minority communities in rural areas.” Your Reference Committee also agreed with an amendment to specifically include reference to mental health. Therefore, your Reference Committee recommends adoption as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(31) RESOLUTION 417 – REDUCING JOB-RELATED CLIMATE RISK FACTORS
RESOLUTION 419 – ADDRESSING THE HEALTH RISKS OF EXTREME HEAT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 417 be adopted in lieu of Resolution 417 and 419.

ADDRESSING THE HEALTH RISKS OF EXTREME TEMPERATURES

1. Our American Medical Association supports the creation of federal occupational outdoor heat standards and the establishment of enforceable indoor temperature standards (addressing both cold and hot temperatures), for occupational settings, incarceration facilities (e.g., prisons, jails, and detention centers), schools, licensed health care and other congregate facilities.

2. our AMA supports funding for cooling and heating centers as well as subsidizing energy costs to provide adequate heating and cooling for low-income households to maintain safe temperatures during periods of extreme temperature.

HOD ACTION: Alternate Resolution 417 be adopted in lieu of Resolution 417 and 419.

RESOLVED, that our American Medical Association support enforcement of existing outdoor health standards and the establishment of enforceable indoor heat and outdoor cold illness prevention standards, for occupational settings, schools, licensed health care and other congregate facilities. (New HOD Policy)

RESOLVED, that our American Medical Association support funding for subsidizing energy costs and air conditioning units for low-income households to maintain safe temperatures during periods of extreme temperature (New HOD Policy); and be it further

RESOLVED, that our AMA support the implementation and enforcement of state and federal temperature standards in prisons, jails, and detention centers, including the implementation of air conditioning in areas that experience dangerously high temperatures. (New HOD Policy)

Your Reference Committee heard testimony in support of these two resolutions and it was noted that they are very similar in intent. Two groups testifying supported the combination

into a single alternate resolution and alternative resolution text was proffered. The original resolution authors testified that they supported the proposed amendment that combined the two resolutions, and the Reference Committee agrees that this new resolution text streamlines the two original resolutions and provides greater clarity. Madam Speaker, your Reference Committee recommends that Alternate Resolution 417 be adopted in lieu of Resolutions 417 and 419.

(32) RESOLUTION 423 – HPV VACCINATION TO PROTECT HEALTHCARE WORKERS OVER AGE 45

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 423 be adopted in lieu of Resolution 423.

1. Our American Medical Association encourages the CDC to review the available evidence for recommending the HPV vaccine for health care professionals to prevent health care related infection of HPV.

2. Our AMA supports the need for additional ongoing research regarding minimization of occupational exposure to HPV, including through use of personal protective equipment.

HOD ACTION: Alternate Resolution 423 be adopted in lieu of Resolution 423.

RESOLVED, that our American Medical Association support all health care workers (HCWs) who might be exposed to HPV in the course of their clinical duties and strongly encourage them to wear masks, preferably N-95 (New HOD Policy); and be it further

RESOLVED, that our AMA will work with appropriate stakeholders to ensure that the HPV vaccine should be offered to all HCWs with potential exposure to HPV oncogenic material at no or minimal cost to the HCW individual (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant stakeholders, including the CDC, to recommend HPV vaccine to HCWs to prevent health care related transmission. (Directive to Take Action)

Your Reference Committee heard mixed testimony on this item. Supportive testimony noted that this resolution explicitly bridges coverage and provides cancer prevention to those older than age 45 who might be exposed to HPV oncogenic material during their treatment of patients. Testimony in opposition noted the limited data available on occupational risk to exposure of HPV oncogenic material. Testimony in opposition to the first Resolve clause noted that it was vague in scope and is not evidence-based. Your Reference Committee agrees with this amendment. Testimony in opposition of Resolve clause 2 and 3 noted conflict with endorsement of off label use of vaccine given that there is no study of the efficacy of the HPV vaccine in these individuals. An amendment was

proffered to include a resolve clause asking for further study of the efficacy of HPV vaccination and the use of PPE to minimize occupational exposure to HPV oncogenic material. Your Reference Committee agrees with this amendment noting the need for continued research on the risk of occupational exposure. Further, an amendment was proffered to address issues with off-label use and the need for a recommendation by CDC's ACIP to ensure reimbursement. Your Reference Committee agrees with this amendment. Madam Speaker, your Reference Committee recommends that Alternate Resolution 423 be adopted in lieu of Resolution 423.

RECOMMENDED FOR REFERRAL

(33) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 10 – TEENS AND SOCIAL MEDIA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that CSAPH Report 10 be referred.

HOD ACTION: Council on Science and Public Health Report 10 be referred.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA:

(1) urges physicians to: (a) educate themselves about social media; (b) be prepared to counsel patients and/or their guardians about the potential risks and harms of social media; and (c) consider expanding clinical interviews to inquire about social media use.
(2) encourages further clinical, epidemiological, and interdisciplinary research on the impact of social media on health.
(3) supports education of clinicians, educators, and the public on digital media literacy and the health effects of social media.
(4) recognizes that the relative risks and benefits of social media may depend on individual differences (e.g., social media engagement, pre-existing traits, and environment).
(5) supports legislative, regulatory, and associated initiatives (e.g., development of industry standards, age-appropriate design, and funding programs that support those harmed by online harassment).
(6) will collaborate with professional societies, industry, and other stakeholders to improve social media platform privacy protections, transparency (e.g., algorithmic, data, and process), data sharing processes, and systems for accountability and redress in response to online harassment. (New HOD Policy)

2. That current AMA policy D-478.965, "Addressing Social Media and Social Networking Usage and its Impacts on Mental Health D-478.965" be amended by addition and deletion to read as follows:

Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage; (2) advocates for schools to provide safe and effective educational programs ~~by which~~ so that (a) all students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage, (b) all students develop skills in digital literacy to serve as an individual protective foundation for interaction with various types of digital media (including social media), and (c) at risk students' access to social media can be limited and/or closely monitored as

individually appropriate; (3) affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions; (4) advocates for and support media and social networking services addressing and developing safeguards for users, including protections for youth online privacy, effective controls allowing youth and caregivers to manage screentime content and access, and development and dissemination of age-appropriate digital literacy training; and (5) advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use. (Modify Current HOD Policy)

Your Reference Committee heard generally supportive testimony with minor revisions proposed to the recommendations. Specifically, one delegation proposed removal of clause 2c in recommendation 2, noting concerns about censorship, and strengthening language around policy interventions in clause 5 of recommendation 2. This was supported by multiple delegations. While there was unanimous support for the amended recommendations, the same delegation had reservations regarding the body of the report and therefore proposed referral of the report. Referral was supported by multiple delegations. Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 10 be referred.

(34) RESOLUTION 402 – GUARDIANSHIP AND CONSERVATORSHIP REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 402 be referred.

HOD ACTION: Resolution 402 be referred.

RESOLVED, that our American Medical Association support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse (New HOD Policy); and be it further

RESOLVED, that our AMA study the impact of less restrictive alternatives to guardianships and conservatorships including supported decision making on medical decision making, health outcomes, and quality of life. (Directive to Take Action)

Your Reference Committee heard mixed testimony on this item. Supportive testimony noted that a study and more data will help medical professionals to make informed recommendations and offer alternatives to establishing guardianship or conservatorship relationships. Testimony also noted the negative impacts of guardianships and conservatorships given the recent issues highlighted from the Britney Spears case. The testimony in opposition noted concerns with the logistical, financial, and ethical barriers of data gathering even if it is anonymized and further noted that it would be difficult to advocate for collecting data if the data currently does not exist. Your Reference Committee agrees and also notes that the ask of this item already calls for a study and should include whether there is any organized database to collect statewide data. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 402 be referred.

(35) RESOLUTION 404 – PROTECTIONS AGAINST SURGICAL SMOKE EXPOSURE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 404 be referred.

HOD ACTION: Resolution 404 be referred.

RESOLVED, that our American Medical Association support efforts to limit surgical smoke exposure in operating rooms. (New HOD Policy)

Your Reference Committee heard mixed testimony on this resolution. While there was testimony on the potential health harms, other delegations noted conflicting research on the subject. Delegations representing some surgical groups cited ergonomic and cost concerns with surgical smoke mitigation interventions, particularly smoke evacuation devices. Based on the mixed testimony, the Reference Committee believes there is a need for further study on this topic. Therefore, Madam Speaker, your Reference Committee recommends that Resolution 404 be referred.

(36) RESOLUTION 427 – CONDEMNING THE UNIVERSAL SHACKLING OF EVERY INCARCERATED PATIENT IN HOSPITALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 427 be referred.

HOD ACTION: Resolution 427 be referred.

RESOLVED, that our American Medical Association condemns the practice of universally shackling every patient who is involved with the justice system while they receive care in hospitals and outpatient health care settings (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the universal assessment of every individual who is involved with the justice system who presents for care, by medical and security staff in collaboration with correctional officers, to determine whether shackles are necessary or may be harmful, and, if restraint is deemed necessary, that the least restrictive alternative to shackling with metal cuffs is used when appropriate (Directive to Take Action; and be it further

RESOLVED, that our AMA advocate nationally for the end of universal shackling, to protect human and patient rights, improve patient health outcomes, and reduce moral injury among physicians. (Directive to Take Action)

Your Reference Committee heard extensive and mixed testimony on this resolution. Those in support highlighted that the practice of universally shackling justice-involved patients in hospitals and outpatient settings is both inhumane and medically unjustifiable. Those in opposition to this resolution cited concern for the safety of medical staff and

noted that tragedies have occurred during this precarious, unpredictable time of transport and provision of care. There were discussions around possible opt-in and opt-out provisions related to shackling and whether medical staff are in the best position to advise on whether shackles are necessary. It was also noted that the terminology is technically inaccurate as written as shackling only refers to restraints on the ankles and does not include handcuffs and belly chains. Your Reference Committee acknowledges the complexity of balancing patient dignity, the safety of health care professionals, and the responsibility of correctional facilities and staff and therefore recommends referral.

RECOMMENDED FOR REFERRAL FOR DECISION

(37) RESOLUTION 421 – ANNUAL CONFERENCE ON THE STATE OF OBESITY AND ITS IMPACT ON DISEASE IN AMERICA (SODA)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 421 be referred for decision.

HOD ACTION: Resolution 421 be referred for decision.

RESOLVED, that our American Medical Association convene an annual meeting of its Federation partners to comprehensively review the impact of obesity on hypertension, cardiovascular disease, type 2 diabetes, metabolic dysfunction-associated hepatitis (MASH) and other related comorbidities with a focus on monitoring epidemiology, developing algorithms to combat disease progression, and coordinating efforts to improve access to care (Directive to Take Action); and be it further

RESOLVED, that our AMA shall feature presentations, workshops, and panel discussions covering the latest research findings, clinical guidelines, and best practices related to the prevention, diagnosis, and management of obesity-related chronic diseases (Directive to Take Action); and be it further

RESOLVED, that our AMA shall invite renowned experts, researchers, clinicians, policymakers, and patient advocates to contribute their insights, experiences, and recommendations during the annual meeting (Directive to Take Action); and be it further

RESOLVED, that our AMA that shall collaborate with relevant stakeholders, including government agencies, healthcare systems, insurers, community organizations, and industry partners, to develop and implement strategies for combating obesity-related chronic diseases (Directive to Take Action); and be it further

RESOLVED, that our AMA assist in the discussion of epidemiological trends, development of evidence-based algorithms for disease management, and coordination of efforts to improve access to care for patients affected by obesity-related chronic diseases (Directive to Take Action); and be it further

RESOLVED, that our AMA shall publish a comprehensive report summarizing the discussions, findings, and recommendations from each annual meeting and disseminate it to member organizations, policymakers, healthcare providers, and the public (Directive to Take Action); and be it further

RESOLVED, that the AMA shall convene the first annual meeting in 2025 and subsequent meetings annually thereafter. (Directive to Take Action)

Your Reference Committee heard general support for bringing organizations together around the issue of obesity. Given the fiscal note, the author raised the possibility of AMA

hosting this meeting during the AMA Annual Meeting to reduce costs. Given the specificity of the multiple resolve statements, it was not clear to your Reference Committee if hosting this event in conjunction with the Annual Meeting would be feasible and whether it would impact the fiscal note. There were also suggested amendments to expand the scope of this to include other conditions. Your Reference Committee believes that this could be a slippery slope with future resolutions asking for similar meetings on specific conditions. Therefore, your Reference Committee recommends that this resolution be referred for decision.

(38) RESOLUTION 426 – MATERNAL MORBIDITY AND MORTALITY: THE URGENT NEED TO HELP RAISE PROFESSIONAL AND PUBLIC AWARENESS AND OPTIMIZE MATERNAL HEALTH – A CALL TO ACTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 426 be referred for decision.

HOD ACTION: Resolution 426 be referred for decision.

RESOLVED, that our AMA policy no. D-245.994 be amended to include the importance of all women achieving their healthiest weight before pregnancy, maintaining healthy gestational weight gain and optimizing weight loss postpartum (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA:
a) Advocate for access to effective obesity treatment (either medical or surgical) for patients.
b) Advocate for supporting physicians' ability to provide obstetrical and obesity care.
c) Advocate for additional funding for research on medical technology that influences human behavior to promote healthy living.
d) Reaffirm policy no. H-440.902 and report back at A-25 on research on the medical, psychological, and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity, emphasizing pre-conception, gestational and postpartum obesity.
e) Provide medical recommendations on ways to eliminate barriers identified in prior obesity research by our AMA.
f) Recommend that approaches to obesity prevention and treatment be included as an element of medical education. (Directive to Take Action)

Your Reference Committee heard limited testimony in support of this resolution as written. A proposed a substitution that amended existing AMA Policy H-425.976 on Preconception Care. The substitution was supported in the hearing and your Reference committee agrees with proposed language. However, because the substitution is an amendment to existing policy that was not addressed in the original resolution, it cannot be adopted. To accomplish the goals of the proposed substitution, your Reference Committee recommends referral for decision so the policy on preconception care can be amended accordingly.

RECOMMENDED FOR NOT ADOPTION

(39) RESOLUTION 434 – UNIVERSAL NEWBORN EYE SCREENING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 434 be not adopted.

HOD ACTION: Resolution 434 be not adopted.

RESOLVED, that our American Medical Association amend AMA policy, Standardization of Newborn Screening Programs H-245.973 by addition and deletion as follows:

Our AMA: (1) recognizes the need for uniform minimum newborn screening (NBS) recommendations; (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases; and (3) supports screening for critical congenital heart defects for newborns following delivery prior to hospital discharge; and (4) endorses Universal Photographic Newborn Screening as a national practice for newborn children. (Modify Current HOD Policy)

Your Reference Committee heard testimony mostly in opposition to this resolution. It was noted that there is no scientific evidence to support the use of this exam in this population. Concerns were expressed both in regard to straining hospital resources and to the potential for false diagnoses with the risk of this screening in this population outweighing the benefits. Therefore, your Reference Committee recommends that this resolution not be adopted.

Madam Speaker, this concludes the report of Reference Committee D. I would like to thank Shaminy Anne Manoranjithan, Shanna M. Combs, MD, Kevin Bernstein, MD, MMS, John Maa, MD, Kim Templeton, MD, and Edward "Chris" Bush, MD; all those who testified before the Committee as well as our AMA staff Andrea Garcia, Jane Sachs, Lindsey Realmuto, and Mary Soliman.

Shaminy Anne Manoranjithan
Regional Medical Student

Shanna M. Combs, MD (Alternate)
Texas Medical Association

Kevin Bernstein, MD, MMS
American Academy of Family Physicians

Edward "Chris" Bush, MD (Alternate)
Michigan State Medical Society

John Maa, MD
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Kim Templeton, MD
American Academy of Orthopaedic Surgeons

Dale M. Mandel, MD
Pennsylvania Medical Society
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-24)

Report of Reference Committee E

Robert Panton, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Science and Public Health Report 2 – Comparative Effectiveness Research
2. Council on Science and Public Health Report 7 – Androgen Deprivation in Incarceration
3. Council on Science and Public Health Report 8 – Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing
4. Council on Science and Public Health Report 12 – Universal Screening for Substance Use and Substance Use Disorders during Pregnancy
5. Resolution 511 - National Penicillin Allergy Day and Penicillin Allergy Evaluation & Appropriate Delabeling
6. Resolution 513 - Biotin Supplement Packaging Disclaimer
7. Resolution 514 - Safety With Devices Producing Carbon Monoxide

RECOMMENDED FOR ADOPTION AS AMENDED

8. Council on Science and Public Health Report 1 – Council on Science and Public Health Sunset Review of 2014 House Policies
9. Council on Science and Public Health Report 4 - Sex and Gender Differences in Medical Research
10. Council on Science and Public Health Report 5 – Biosimilar/Interchangeable Terminology
    Resolution 504 - FDA Regulation of Biosimilars
11. Resolution 502 – Tribally-Directed Precision Medicine Research
12. Resolution 505 - Mitigating the Harms of Colorism and Skin Bleaching Agents
13. Resolution 507 - Ban on Dual Ownership, Investment, Marketing or Distribution of Recreational Cannabis by Medical Cannabis Companies
14. Resolution 509 - Addressing Sarcopenia and its Impact on Quality of Life
    Resolution 517 – Regulation of Nicotine Analogue Products

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

15. Resolution 515 - Advocacy for More Stringent Regulations/Restrictions on the Distribution of Marijuana

RECOMMENDED FOR REFERRAL

16. Resolution 501 - Fragrance Regulation

RECOMMENDED FOR NOT ADOPTION

17. Resolution 506 - Screening for Image Manipulation in Research Publications

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

18. Resolution 503 - Unregulated Hemp-Derived Intoxicating Cannabinoids, and Derived Psychoactive Cannabis Products (DPCPs)
19. Resolution 508 - AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis
20. Resolution 510 - Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and “Natural Cures”
21. Resolution 512 - Opioid Overdose Reversal Agents Where AED’s Are Located

For the purposes of clarity, items marked with double underline or ~~double strikethrough~~ are highlighted in yellow.

Amendments

If you wish to propose an amendment to an item of business, click here:

SUBMIT NEW AMENDMENT

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 – COMPARATIVE EFFECTIVENESS RESEARCH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 2 adopted as amended and the remainder of the report filed.

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:
(1) That policy H-450.922, "Comparative Effectiveness Research" be amended by deletion to read as follows:
~~Our AMA will:~~
~~(1) study the feasibility of including comparative effectiveness studies in various FDA drug regulatory processes, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter; and~~
~~(2)~~ ask the National Institutes of Health to support and fund comparative effectiveness research for approved drugs, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter. (Amend HOD Policy)
(2) That policies H-120.988, "Patient Access to Treatments Prescribed by Their Physicians", and H-460.909, "Comparative Effectiveness Research" be reaffirmed. (Reaffirm HOD Policy)
(3) That our AMA support efforts to encourage and incentivize premarket comparative effectiveness research comparing emerging medications to existing treatment options to increase transparency about a treatment's efficacy once approved.

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:
(1) That policy H-450.922, "Comparative Effectiveness Research" be amended by deletion to read as follows:
~~Our AMA will:~~
~~(1) study the feasibility of including comparative effectiveness studies in various FDA drug regulatory processes, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter; and~~
~~(2)~~ ask the National Institutes of Health to support and fund comparative effectiveness research for approved drugs, including comparisons with existing standard of care,

available generics and biosimilars, and drugs commonly used off-label and over-the-counter. (Amend HOD Policy)
(2) That policies H-120.988, "Patient Access to Treatments Prescribed by Their Physicians", and H-460.909, "Comparative Effectiveness Research" be reaffirmed. (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony for comparative effectiveness research as a general concept, but with a mixed discussion as to the most appropriate way for it to be utilized as a federal regulatory tool. On one hand, testimony cited the need for comparative effectiveness research to be a tool primarily left for clinical decision-making, while others felt that federal regulatory bodies could benefit from including it into their regulatory activities, either implicitly or explicitly. However, testimony described how inviting the FDA or CMS to even investigate these matters, even if not used for regulatory decisions, would require undue resources and potentially bias decision-making. Amendments were proffered to increase funding for comparative effectiveness research generally, but your Reference Committee finds that these requests are current policy of our AMA and reaffirmed via the original recommendations of this report. As such, your Reference Committee recommends that Council on Science and Public Health Report 2 be adopted.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 7 – ANDROGEN DEPRIVATION IN INCARCERATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 7 be adopted and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 7 adopted and the remainder of the report filed.

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:
1. That Policy H-430.977, "AMA Study of Chemical Castration in Incarceration" be rescinded. (Rescind HOD Policy)
2. That our AMA:
a. Opposes laws, regulations, and actions of the court which remove physician autonomy and clinical judgement from treatment decisions regarding androgen deprivation (also known as chemical castration) for those convicted of sexual crimes.
b. Opposes linkages of criminal sentencing, parole, or probation to court-mandated androgen deprivation.
c. Encourages data collection on the utilization, court mandates, duration of therapy, and clinical outcomes of androgen deprivation in the carceral setting.
d. Supports continued research for effective treatments for paraphilic disorders, including efforts to reduce stigma and recruit patients with paraphilic disorders into clinical trials. (New HOD Policy)
3. That Policies D-430.997, "Support for Health Care Services to Incarcerated Persons," H-430.978 "Improving Care to Lower the Rate of Recidivism," and H-345.981 "Access to Mental Health Services" be reaffirmed. (Reaffirm HOD Policy)

Your Reference Committee heard overall agreement for the sentiment that medication, including those used for androgen deprivation, should never be used as punishment. However, some testimony described an ongoing tension around its use and the approach to incarceration. Testimony cited the desire to have more options for patients to avoid or reduce their time incarcerated and the significant negative health impacts it can have, while also recognizing that it would be impossible to provide truly informed, uncoerced consent for androgen deprivation treatment when the alternative is imprisonment. Your Reference Committee heard testimony describing how the use of the term "court-mandated" in the original report recommendations should allow for our AMA to advocate for treatment of paraphilic disorders. Such treatment should be guided by the patient-physician relationship and could be used as the basis for a modified criminal sentence, but would not mandate the use of a specific medication. As such, your Reference Committee recommends that Council on Science and Public Health Report 7 be adopted.

(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 8 – DECREASING REGULATORY BARRIERS TO APPROPRIATE TESTOSTERONE PRESCRIBING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 8 be adopted and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 8 adopted and the remainder of the report filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That policy D-270.983, "Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing," be amended by addition to read as follows:

A. Our AMA will ask the FDA to review the available evidence and other data on testosterone and submit updated recommendations, if warranted, to the DEA, for its consideration of the scheduling of testosterone-containing drug products.

B. Our AMA supports policies to remove barriers that delay or impede patient access to prescribed testosterone. (New HOD Policy)

C. Our AMA will continue to work alongside our partner organizations to promote advocacy and physician education on testosterone prescribing. (New HOD Policy)

2. That Policies H-65.976, "Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations," H-140.824, "Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population," H-160.991, "Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations," H-185.927 "Clarification of Evidence-Based Gender-Affirming Care," H-95.946, "Prescription Drug Monitoring Program Confidentiality," H-315.983, "Patient Privacy and Confidentiality," D-185.981, "Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act," and D-480.964, "Established Patient Relationships and Telemedicine" be reaffirmed. (Reaffirm HOD Policy)

Your Reference Committee received widespread support for this report. Testimony highlighted the necessity of ensuring access to prescribed testosterone when clinically indicated, particularly as a part of gender-affirming care. Testimony noted this medication is crucial for transgender, non-binary, and gender-diverse individuals, whose access to such care has been threatened or criminalized. Further, testimony recognized the importance of testosterone for patient well-being and health. As such, your Reference Committee recommends that this report be adopted.

(4) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 12 – UNIVERSAL SCREENING FOR SUBSTANCE USE AND SUBSTANCE USE DISORDERS DURING PREGNANCY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 12 be adopted and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 12 adopted and the remainder of the report filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA:

A. Encourage ongoing research on the benefits and risks of universal screening for substance use during pregnancy including the impact of mandatory reporting laws, evaluation of patient outcomes, effectiveness across different age groups, optimal screening intervals, equity considerations, and efficacy of different screening tools.

B. Support the development and dissemination of physician education and training on federal and state laws governing mandatory notification and reporting of substance use during pregnancy, and the benefits and consequences of screening implementation in health care settings on a state-by-state basis. (New HOD Policy)

2. That AMA policy H-420.950, "Substance Use Disorders During Pregnancy," be amended by addition and deletion to read as follows:

Our AMA will:

(1) support brief interventions (such as engaging a patient in a short conversation, providing feedback and advice) and referral for early comprehensive treatment of pregnant individuals with opioid use and opioid use disorder (including naloxone or other overdose reversal medication education and distribution) using a coordinated multidisciplinary approach without criminal sanctions;

(2) acknowledges the health benefits of identifying substance use during pregnancy and opposes any efforts, including mandatory reporting laws, that ~~to~~ imply ~~that~~ a positive verbal substance use screen, a positive toxicology test, or the diagnosis of substance use disorder during pregnancy automatically represents child abuse or neglect;

(3) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy;

(4) oppose the filing of a child protective services report or the removal of infants from their ~~mothers~~ parent(s) solely based on a ~~single positive~~ prenatal drug screen and/or biological test(s) for substance use without appropriate evaluation;

(5) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected or confirmed; and

(6) advocate that state and federal child protection laws be amended so that pregnant people with substance use and substance use disorders are only reported to child welfare agencies when protective concerns are identified by the clinical team, rather than through automatic or mandated reporting of all pregnant people with a positive toxicology test, positive verbal substance use screen, ~~or~~ diagnosis of a substance use disorder, or use of evidence-based treatments for substance use disorder. (Modify Current HOD Policy)
That current AMA policies H-420.969, "Legal Interventions During Pregnancy," and D-95.983, "Mandatory Drug Screening Reporting" be reaffirmed. (Reaffirm HOD Policy)

Testimony heard for this report was overwhelmingly supportive noting the conflict between the importance of universal screening during pregnancy to improve health outcomes and the need for caution due to punitive policies such as mandatory reporting laws. Testimony emphasized the need for ongoing research and education of physicians on state and federal laws that impact their practice to assist in navigating the changing landscape. A single testimony in opposition stated that everyone should be screened to minimize the impact of substance use disorder in the United States. As such, your Reference Committee recommends the report be adopted.

(5) RESOLUTION 511 - NATIONAL PENICILLIN ALLERGY DAY AND PENICILLIN ALLERGY EVALUATION & APPROPRIATE DELABELING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 511 be adopted.

HOD ACTION: Resolution 511 adopted.

1. That National Penicillin Allergy Day, September 28, be recognized by the American Medical Association.

2. Our AMA promotes penicillin allergy evaluation and appropriate delabeling.

Your Reference Committee heard mostly supportive testimony on this item. Several testified to their own personal experiences treating patients labeled as having a penicillin allergy. Specifically, patients were erroneously deemed to have a penicillin allergy as a child due to concomitant viral rash while on penicillin. This has a longstanding impact on treatment options throughout their lifetime as well as antibiotic stewardship. Several noted the availability of a reliable skin test that can be performed in the clinic. While a few questioned the necessity of a specific day, this was rendered as a simple mechanism to raise awareness. As such, your Reference Committee recommends Resolution 511 be adopted.

(6) RESOLUTION 513 - BIOTIN SUPPLEMENT PACKAGING DISCLAIMER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 513 be adopted.

HOD ACTION: Resolution 513 adopted.

1. Our American Medical Association supports efforts to have over-the-counter biotin supplements provide a clear disclaimer on the bottle that states the possibility of lab test interference.

2. Our AMA advocates for greater awareness among both patients and physicians in regards to biotin megadose interference.

Your Reference Committee heard unanimously supportive testimony on this item. Testimony described how utilizing over-the-counter biotin supplements can confound blood test results, and the importance of counseling and awareness to prevent these easily avoidable issues. As such, your Reference Committee recommends Resolution 513 be adopted.

(7) RESOLUTION 514 - SAFETY WITH DEVICES PRODUCING CARBON MONOXIDE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 514 be adopted.

HOD ACTION: Resolution 514 adopted.

1. Our American Medical Association supports the United States Consumer Product Safety Commission in implementing higher safety standards for consumer products that produce carbon monoxide.

2. Our AMA supports public education efforts to minimize harm caused by carbon monoxide poisoning produced in enclosed spaces or too close to exterior openings.

Your Reference Committee heard limited but supportive testimony for this item. The testimony described the tragedy of carbon monoxide poisoning because of unsafe generator usage during the 2021 ice storms in Texas, and how regulators and the industry have been sluggish to respond. As such, your Reference Committee recommends that Resolution 514 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(8) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 - COUNCIL ON SCIENCE AND PUBLIC HEALTH SUNSET REVIEW OF 2014 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 1 be amended by addition and deletion to read as follows:

That our American Medical Association policies listed in the appendix to this report be acted upon in the manner indicated, with the exception of Policies H-120.975 and H-440.922, which should be amended by addition and deletion to read as follows:

Certifying ~~Indigent~~ Patients Unable to Pay for Pharmaceutical Manufacturers' Free Drug Programs

Our AMA: (1) supports Pharmaceutical Research and Manufacturers of America (PhRMA) programs for patients unable to pay and the development of a universal application process, eligibility criteria and form for all prescription drug patient assistance programs to facilitate enrollment of patients and physicians; (2) encourages PhRMA to provide information to physicians and hospital medical staffs about member programs that provide pharmaceuticals to patients unable to pay; (3) urges drug companies to develop user-friendly and culturally sensitive uniform centralized policies and procedures for certifying free or discounted medications for patients unable to pay; and (4) opposes the practice of charging patients to apply for or gain access to pharmaceutical assistance programs.

Gambling Disorder ~~Can Become Compulsive Behavior~~ H-440.922
The AMA: (1) encourages physicians to advise their patients of the addictive potential of gambling; (2) encourages states which operate gambling programs to provide a fixed percentage of their revenue for education, prevention and treatment of gambling disorder; and (3) requests that states which operate gambling programs affix to all lottery tickets and display at all lottery counters a sign which states that gambling may become a gambling disorder and help is available through your local gambling hotline.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 1 adopted as amended and the remainder of the report filed.

The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony for the annual sunset review of 2014 policies, with editorial amendments to align grammar and/or person-first language where appropriate. As such, your Reference Committee recommends adoption as amended.

(9) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 – SEX AND GENDER DIFFERENCES IN MEDICAL RESEARCH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 4 be amended by addition and deletion to read as follows:

That policy H-525.988, "Sex and Gender Differences in Medical Research" be amended by addition and deletion to read as follows:
Our AMA:
(1) reaffirms that gender and sex exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include people of all ~~genders~~ sexes and gender identities and expressions in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender ~~minorities~~ minority communities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender ~~minorities~~ minority individuals from diverse cultural and ethnic groups, geographic locations, and socioeconomic status;
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex based and gender-based analysis of data, even if such comparisons are negative; and
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender ~~minorities.~~ minority individuals; and
(7) supports the FDA's requirement of actionable clinical trial diversity action plans from drug and device sponsors that include women~~,~~ and sexual and gender ~~minorities~~ minority populations; and
(8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing studies which evaluate the efficacy and safety of those products in women and sexual and gender ~~minorities~~ minority populations when those groups were not adequately represented in clinical trials; and
(9) supports and encourages the National Institutes of Health and other grant-making entities to fund post-market research investigating pharmacodynamics and pharmacokinetics for generic drugs that did not adequately enroll women~~,~~ and sexual and gender ~~minorities~~ minority populations in their clinical trials, prioritizing instances when those populations represent a significant portion of patients or reported adverse drug events. (Amend HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 4 be adopted as amended and the remainder be filed.

HOD ACTION: Council on Science and Public Health Report 4 adopted as amended and the remainder filed.

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:
That policy H-525.988, "Sex and Gender Differences in Medical Research" be amended by addition and deletion to read as follows:
Our AMA:
(1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include all genders in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status;
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative; and
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities.; and
(7) supports the FDA's requirement of actionable clinical trial diversity action plans from drug and device sponsors that include women, and sex and gender minorities; and
(8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing studies which evaluate the efficacy and safety of those products in women and sex and gender minorities when those groups were not adequately represented in clinical trials; and
(9) supports and encourages the National Institute of Health and other grant-making entities to fund post-market research investigating pharmacodynamics and pharmacokinetics for generic drugs that did not adequately enroll women, and sex and gender minorities in their clinical trials, prioritizing instances when those populations represent a significant portion of patients or reported adverse drug events. (Amend HOD Policy)

Your Reference Committee heard unanimously supportive testimony on this item, citing the urgent need to increase women and sexual and gender minority community participation in clinical research, both as participants and as researchers themselves. Several testified to their own experiences managing patient care for individuals who have not been represented in clinical trials, further highlighting the timeliness of this policy. One editorial amendment was offered to streamline the language which your Reference

Committee found friendly. As such, your Reference Committee recommends that Council on Science and Public Health Report 4 be adopted as amended.

(10) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 – BIOSIMILAR/INTERCHANGEABLE TERMINOLOGY
RESOLUTION 504 - FDA REGULATION OF BIOSIMILARS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third recommendation of Council on Science and Public Health Report 5 be amended by addition and deletion to read as follows:

3. That Policy D-125.989 "Substitution of Biosimilar Medicines and Related Medical Products" be amended by addition and deletion to read as follows:
Our AMA urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena: (1) preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients; (2) allow substitution when physicians expressly authorize substitution of ~~an interchangeable~~ a biologic or biosimilar product; (3) ~~limit the authority of pharmacists to automatically substitute only those biosimilar products that are deemed interchangeable by the FDA.~~ in the absence of express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when (a) the biologic product is highly similar to the reference product, notwithstanding minor differences in clinically inactive components; and (b) there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product; and (c) the prescribing physician has been adequately notified by the pharmacist. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 5 be amended by addition of a fifth recommendation to read as follows:

5. That our AMA support evidence-based physician education on the clinical equivalence of biosimilars, the FDA approval process, and post-market surveillance requirements. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that recommendations in Council on Science and Public Health Report 5 be adopted in lieu of Resolution 504.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report 5 be filed.

HOD ACTION: Council on Science and Public Health 5 adopted in lieu of Resolution 504 as amended.

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:
1. That Policy H-125.976, "Biosimilar Interchangeability Pathway" be rescinded. (Rescind HOD Policy)
2. That our AMA encourage the FDA to continually collect data and critically evaluate biosimilar utilization including the appropriateness of the term "interchangeable" in regulatory activities. (Directive to Take Action)
3. NEW
4. That Policy D-125.987, "Biosimilar Product Naming and Labeling" be reaffirmed. (Reaffirm HOD Policy)

RESOLVED, that our American Medical Association recognize that, by definition, Biosimilar medications are clinically equivalent to their reference Biologic and therefore do not need a designation of "interchangeability;" (New HOD Policy); and be it further

RESOLVED, that our AMA support a rigorous approval process for Biosimilar medications and oppose the application of the redundant designation of "interchangeability" with the reference biologic drug (New HOD Policy); and it be further

RESOLVED, that AMA support the development of a model and a process for biologic and biosimilar medication prescribing that protects physician decision-making when a pharmacy-level substitution is not clinically appropriate (New HOD Policy); and be it further

RESOLVED, that our AMA support physician education on the clinical equivalence of Biosimilars, the FDA approval process and the post-market surveillance that is required. (New HOD Policy)

Your Reference Committee heard testimony unanimously in support of biosimilars as a class of medication that are critically important for stabilizing and lowering the price of expensive biologic medicines. However, there was an important but nuanced discussion as to the best tactic for our AMA to adopt regarding the term "interchangeable". On the one hand, testimony cited recent research from American regulatory scientists and the experiences of the European regulatory agencies, having concluded that the term

interchangeable is an unnecessary regulatory category, which needlessly prevents patients from accessing safe and effective medicine. They felt our AMA should strongly oppose such a designation. On the other hand, others stated that the FDA has already indicated their desire to remove the interchangeable designation, and our AMA would achieve the same result by taking a more supportive and less prescriptive stance with the FDA. Additionally, proponents of the latter approach noted the difficulties with unwinding state pharmacy laws and the relative infancy of biosimilars research would make a declarative statement premature. There was discussion as to the development of a process for performing and reporting biosimilar substitutions as noted in Resolution 504, which your Reference Committee feels is adequately addressed by the Council recommendations as amended. As such, your Reference Committee recommends that amended Council on Science and Public Health Report 5 be adopted in lieu of Resolution 504.

(11) RESOLUTION 502 - TRIBALLY-DIRECTED PRECISION MEDICINE RESEARCH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 502 be amended by deletion to read as follows:

Our American Medical Association supports clinical funding supplements to the National Institutes of Health, the U.S. Food and Drug Administration, and the Indian Health Service to promote greater participation of the Indian Health Service, Tribal, and Urban Indian Health Programs in research.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 502 be adopted as amended.

HOD ACTION: Resolution 502 adopted as amended.

RESOLVED, that our American Medical Association support clinical funding supplements to the National Institutes of Health, the U.S. Food and Drug Administration, and the Indian Health Service to promote greater participation of the Indian Health Service, Tribal, and Urban Indian Health Programs in clinical research.

Your Reference Committee heard testimony in overwhelming support of funding tribally-directed precision medicine research. Testimony underscored the critical need for Indigenous populations to be actively included in research. Speakers highlighted the unique genetic, environmental, and cultural factors affecting these communities, which can significantly influence health outcomes. By funding tribally-directed research, we can also ensure that precision medicine approaches are tailored to address the specific health needs and disparities faced by Indigenous peoples. This inclusion is not only a matter of equity but also essential for the advancement of medical knowledge and the development of more effective, culturally appropriate healthcare interventions. Thus, your Reference Committee strongly recommends that this proposal be adopted as amended.

(12) RESOLUTION 505 - MITIGATING THE HARMS OF COLORISM AND SKIN BLEACHING AGENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 505 be amended by deletion to read as follows:

~~**RESOLVED, that our American Medical Association support efforts to reduce the unsupervised use of skin lightening agents, especially due to colorism or social stigma, that do not limit evidence-based use by qualified clinicians (New HOD Policy); and be it further**~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 505 be amended by addition of a new first resolve to read as follows:

RESOLVED, That our AMA work with all relevant stakeholders to affirm the longstanding and evolving evidence-based use of skin lightening agents; and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 505 be amended by addition of a new second resolve to read as follows:

RESOLVED, That our AMA work with the World Medical Association and other interested parties to advocate for public education regarding appropriate medical utilization of skin lightening agents and the harms of skin lightening motivated by cultural stigma and colorism; and be it further

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 505 be amended by deletion to read as follows:

~~**RESOLVED, That our AMA work with the World Medical Association and other interested parties to mitigate the harms of colorism and unsupervised use of skin lightening agents. (Directive to Take Action)**~~

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 505 be adopted as amended.

HOD ACTION: Resolution 505 adopted as amended.

RESOLVED, that our American Medical Association support efforts to reduce the unsupervised use of skin lightening agents, especially due to colorism or social stigma, that do not limit evidence-based use by qualified clinicians (New HOD Policy); and be it further

RESOLVED, that our AMA work with the World Medical Association and other interested parties to mitigate the harms of colorism and unsupervised use of skin lightening agents. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 505. There was testimony in support of the intent to protect individuals from skin-lightening or bleaching products when used inappropriately. Testimony described how the social pressures of structural racism often place an unhealthy and oversized emphasis on lighter skin tones. When faced with these social pressures and stigma, individuals can turn to unsafe products that can cause severe damage to their skin and increase their risk for cancer just to achieve a lighter skin tone. However, testimony noted that as written, this resolution may inadvertently capture instances where skin-lightening is medically indicated, such as in pigment disorders. An amendment was proffered to delineate these situations. As such, your Reference Committee recommends that Resolution 505 be adopted as amended.

(13) RESOLUTION 507 - BAN ON DUAL OWNERSHIP, INVESTMENT, MARKETING OR DISTRIBUTION OF RECREATIONAL CANNABIS BY MEDICAL CANNABIS COMPANIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 507 be amended by addition and deletion to read as follows:

Our American Medical Association supports a permanent ban on medical cannabis, psychedelic agent, and/or empathogenic agent companies (and their related holding conglomerates) from owning, investing in, distributing, or promoting recreational (or "adult use") cannabis, psychedelic agents, and/or empathogenic agents or any other activity relating to recreational use of cannabis, psychedelic agents, and/or empathogenic agents. **(New HOD Policy)**

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 507 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 507 be changed to read as follows:

BAN ON DUAL OWNERSHIP, INVESTMENT, MARKETING OR DISTRIBUTION OF ADULT-USE CANNABIS, PSYCHEDELIC AGENTS, OR EMPATHOGENS BY MEDICAL COMPANIES
HOD ACTION: Resolution 507 adopted as amended with a change in title.

RESOLVED, that our American Medical Association support a permanent ban on medical cannabis companies (and its related holding conglomerates) from owning, investing in, distributing, or promoting recreational (or "adult use") cannabis or any other activity relating to recreational use of cannabis. (New HOD Policy)

Your Reference Committee heard limited but supportive testimony on this item. Those that testified in support described how cannabis companies may face a conflict of interest while producing products intended for medical usage, while simultaneously lobbying for their products to be sold to any consumer. One specialty group testified that they are supportive of this approach generally and offered an amendment to expand the approach to include other classes of drugs, such as psychedelic agents or empathogens. As such, your Reference Committee recommends adoption as amended.

(14) RESOLUTION 509 - ADDRESSING SARCOPENIA AND ITS IMPACT ON QUALITY OF LIFE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 509 be amended by addition and deletion to read as follows:

Our American Medical Association supports educational awareness targeting healthcare professionals, caregivers, and at-risk populations to increase knowledge about sarcopenia, its risk factors and consequences, in order to facilitate prevention, early recognition and evidence-based management as a routine part of clinical practice.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 509 be adopted as amended.

HOD ACTION: Resolution 509 adopted as amended.

RESOLVED, that our American Medical Association collaborate with appropriate entities to develop and implement educational awareness targeting healthcare professionals, caregivers, and the elderly population to increase knowledge about sarcopenia, its risk factors and consequences, in order to facilitate prevention, early recognition and evidence-based management as a routine part of clinical practice with elderly patients (Directive to Take Action); and be it further

RESOLVED, that our AMA (1) support nutritional interventions aimed at optimizing protein intake, essential amino acids, and micronutrients; (2) promote regular physical activity, including resistance training, aerobic exercise, and balance exercises, tailored to individual capabilities and preferences (New HOD Policy); and be it further

RESOLVED, that our AMA support allocation of resources for research initiatives aimed at advancing our understanding of sarcopenia, its pathophysiology, risk factors, and treatment modalities (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for policy changes to support reimbursement for sarcopenia screening, diagnosis, and interventions (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with all stakeholders to integrate sarcopenia prevention and management into public health agendas and aging-related initiatives. (Directive to Take Action)

Your Reference Committee heard testimony unanimously in support of the underlying intent behind this resolution. Testimony described how the American population is aging, and there is generally low awareness for diagnosing, subsequent treatment, and the reimbursement landscape for sarcopenia. However, several testifying noted the large fiscal note attached to this resolution, and an amendment was proffered to retain the

intent of the resolution while communicating that our AMA would not be the sole entity responsible for creating this content. It is expected that this amendment would lower the estimated fiscal note without precluding our AMA from acting. Additional amendments were recommended to modify the scope to include that sarcopenia may impact any patient, particularly those using weight loss medications. As such, your Reference Committee recommends Resolution 509 be adopted as amended.

(15) RESOLUTION 517 – REGULATION OF NICOTINE ANALOGUE PRODUCTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 517 be amended by deletion to read as follows:

2. Our AMA urges the Food and Drug Administration ~~(FDA) Center for Drug Effectiveness and Research~~ swiftly exert its authority to regulate all nicotine analogue products as drugs (Directive to Take Action).

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 517 be adopted as amended.

HOD ACTION: Resolution 517 adopted as amended.

1. Our American Medical Association opposes the development, production market and sales of nicotine analogue consumer products.

RESOLVED, that our AMA urge the Food and Drug Administration (FDA) Center for Drug Effectiveness and Research swiftly exert its authority to regulate all nicotine analogue products as drugs (Directive to Take Action).

Your Reference Committee heard unanimously supportive testimony of the intent of this resolution. Testimony described the frustrations of trying to keep up with the rapidly evolving landscape of tobacco and nicotine products, many of which are currently being designed to circumvent the regulations specifically in place to protect the public's well-being. Your Reference Committee does proffer one amendment to strike reference to a specific entity within the FDA, as there are other groups such as the Center for Tobacco Products, which may also be appropriate targets for advocacy by our AMA. As such, your Reference Committee recommends adoption as amended.

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

(16) RESOLUTION 515 - ADVOCACY FOR MORE STRINGENT REGULATIONS/RESTRICTIONS ON THE DISTRIBUTION OF MARIJUANA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 515 be adopted with change in title to read as follows:

ADVOCACY FOR MORE STRINGENT REGULATIONS/RESTRICTIONS ON THE DISTRIBUTION OF CANNABIS

HOD ACTION: Resolution 515 adopted with a change in title.

Our American Medical Association will study possible legislative, legal or regulatory means to make the cannabis industry responsible for increasing costs of medical and social care for people affected by the problems caused by cannabinoids similar to regulations for smoking cessation in the United States.

Your Reference Committee heard limited but supportive testimony for this item. Testimony noted that there is a need for a change in the name of the resolution from marijuana to cannabis to be consistent with other policies. Additionally, testimony spoke to the need to cover the costs of treatment, since the industry is creating more potent products and patients often have adverse effects. As such, your Reference Committee recommends that Resolution 515 be adopted.

RECOMMENDED FOR REFERRAL

(17) RESOLUTION 501 – FRAGRANCE REGULATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 501 be referred.

HOD ACTION: Resolution 501 referred.

RESOLVED, that our American Medical Association recognize fragrance sensitivity as a disability where the presence of fragranced products can limit accessibility of healthcare settings (New HOD Policy); and be it further

RESOLVED, that our AMA encourage all hospitals, outpatient clinics, urgent cares, and other patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to employees, patients, and visitors of any kind (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant parties to advocate for governmental regulatory bodies, including but not limited to the Occupational Safety and Health Administration (OSHA), the Centers for Disease Control and Prevention (CDC), and the National Institute for Occupational Safety and Health (NIOSH) to recommend fragrance-free policies in all medical offices, buildings, and places of patient care (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant parties to support the appropriate labeling of fragrance-containing personal care products, cosmetics, and drugs with warnings about possible allergic reactions or adverse events due to the fragrance, and advocates for increased categorization in the use of a “fragrance free” designation (Directive to Take Action); and be it further

RESOLVED, that our AMA support increased identification of hazardous chemicals in fragrance compounds, as well as research focused on fragrance sensitivity in order to remove these allergens from products applied to one’s body. (New HOD Policy)

Your Reference Committee heard significant mixed testimony on this item. Proponents cited poor regulations for the labeling of fragrances and potential allergens in many consumer products, and the impact these products can have on a patient’s ability to access care. Conversely, opponents described how blanket fragrance-free policies may also exclude patients from receiving care and place physicians in legal jeopardy, such as in instances where a patient with a scented product may be seeking emergency care. While there were disagreements as to the feasibility of larger fragrance-free policies, there was a consensus around the desire for our AMA to investigate the “fragrance-free” designation for consumer products, and the correct labeling of allergens. Additionally, there was significant disagreement as to whether it was appropriate to designate fragrance sensitivity as a disability. While several amendments were offered to alleviate some concerns, there did not appear to be a consensus formed as to the direction our

AMA should take. As such, your Reference Committee recommends that Resolution 501 be referred.

RECOMMENDED FOR NOT ADOPTION

(18) RESOLUTION 506 - SCREENING FOR IMAGE MANIPULATION IN RESEARCH PUBLICATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 506 be not adopted.

HOD ACTION: Resolution 506 referred.

RESOLVED, that our American Medical Association support the creation of a nationally collaborative database of manipulated images from retracted publications to provide a test bank for researchers developing augmented intelligence-integrated image screening tools. (New HOD Policy)

Your Reference Committee heard testimony in opposition to this resolution. Testimony noted the lack of a standardized tool to identify manipulated images for this use and the necessity of a database for this purpose. Testimony questioned whether our AMA was the appropriate entity to be pursuing these measures, and that several publishers are already pursuing or utilize their own image detection software. Therefore, your Reference Committee recommends Resolution 506 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(19) RESOLUTION 503 - UNREGULATED HEMP-DERIVED INTOXICATING CANNABINOIDS, AND DERIVED PSYCHOACTIVE CANNABIS PRODUCTS (DPCPS)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that policies H-95.952 and H-95.940 be reaffirmed in lieu of Resolution 503.

HOD ACTION: Resolution 503 referred for decision.

RESOLVED, that our American Medical Association work with other interested organizations to increase public awareness and promote education on the dangers of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids (Directive to Take Action); and be it further

RESOLVED, that our AMA work with other interested organizations to advocate to close the loophole in the 2018 Farm bill that allows Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids to be regulated as hemp (Directive to Take Action); and be it further

RESOLVED, that our AMA work with other interested organizations to advocate for prohibition of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids (unless and until properly tested in humans) (Directive to Take Action); and be it further

RESOLVED, that our AMA work with other interested organizations to advocate for further research on the health impacts of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids, including the potential dangers of these products to children, pregnant women and other vulnerable populations (Directive to Take Action); and be it further

RESOLVED, that our AMA report back on this issue at A-25. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 503. Speakers who testified in opposition noted the significant body of work completed by your Council on Science and Public Health on emerging trends in new psychoactive substances and cannabinoids more broadly. This resolution is covered by existing policy, H-95.952 and H-95.940 (below), and your Reference Committee questions whether new policies are needed for every new chemical compound. Further, opposing testimony noted that advocating for legislation related to the 2018 Farm Bill may cause unwanted conflicts with farming groups. As such, your Reference Committee recommends that these policies are reaffirmed in lieu of Resolution 503.

Cannabis and Cannabinoid Research H-95.952

1. Our American Medical Association calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled

evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.

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

Addressing Emerging Trends in Illicit Drug Use H-95.940

Our AMA: (1) recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat; (2) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, other educational materials, and public awareness campaigns; (3) supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiologic surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders; (4) encourages adequate federal and state funding of agencies tasked with addressing the emerging drugs of abuse health threat; (5) encourages the development of continuing medical education on emerging trends in illicit drug use; and (6) supports efforts by federal, state, and local government agencies to identify

new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner.

(20) RESOLUTION 508 - AMA TO SUPPORT REGULATIONS TO DECREASE OVERDOSES IN CHILDREN DUE TO INGESTION OF EDIBLE CANNABIS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that policy H-95.924 be reaffirmed in lieu of Resolution 508.

HOD ACTION: Resolution 508 referred for decision.

RESOLVED, that our American Medical Association work with the Food and Drug Administration to strengthen how marijuana manufacturers can advertise their products, including regulations that ensure the packaging does not appeal to children (Directive to Take Action); and be it further

RESOLVED, that our AMA propose public awareness campaigns aimed at informing the general population, especially parents and guardians, about the risks associated with edible cannabis and the importance of safe storage and handling (Directive to Take Action); and be it further

RESOLVED, that our AMA emphasize the importance of childproof packaging for all cannabis products, along with advocating for stricter regulations to enforce this requirement. (New HOD Policy)

Your Reference Committee heard supportive testimony that highlighted the urgent need for stricter regulations on how cannabis products are packaged and advertised. Strong support exists for this initiative, particularly due to concerns that parents may underestimate the safety risks, necessitating education for both parents and youth. Testimonies revealed alarming incidents where children suffered adverse events as current packaging often resembles candy or vitamins. Your Reference Committee reviewed current cannabis policy, H-95.924 (below), and determined that current policy encompasses the intent of this resolution, to strengthen regulations to educate the public, and support childproof packaging. As such, your Reference Committee recommends reaffirming policy H-95.924, “Cannabis Legalization for Adult Use.”

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

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

regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth.

5. Our AMA believes laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness.
6. Our AMA encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder.
7. Our AMA supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use.
8. Our AMA encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety.
9. Our AMA encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis.
10. Our AMA will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving.
11. Our AMA supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities.
12. Our AMA will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

(21) RESOLUTION 510 - STUDY TO INVESTIGATE THE VALIDITY OF CLAIMS MADE BY THE MANUFACTURERS OF OTC VITAMINS, SUPPLEMENTS AND "NATURAL CURES"

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that policy H-150.954 be reaffirmed in lieu of Resolution 510.

HOD ACTION: Policy H-150.954 reaffirmed in lieu of Resolution 510.

RESOLVED, that our American Medical Association study the growing problem of advertisements on OTC Vitamins, Supplements, and "Natural Cures" that claim health benefits and cures. With report back at A-25 (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with all the specialties which are affected by these claims and gather scientific evidence showing benefits and false claims (Directive to Take Action); and be it further

RESOLVED, that our AMA request that the FDA exercise its full scope of authority to protect our patients by removing all the advertisements containing false claims of medical cures. (Directive to Take Action)

Your Reference Committee heard testimony that was supportive of increased regulations on dietary supplement manufacturers, but mixed as to whether the proposed resolution was the appropriate method to achieve those goals. Testimony noted that our AMA has extensive policy on dietary supplements and the role of the FDA in regulating them, and has a demonstrated history of advocacy on this issue. Your Reference Committee would note that our AMA has collaborated with other stakeholders in the Dietary Supplement Quality Collaborative, written to Congress on mandatory product listing for dietary supplements, and developed award-winning continuing medical education in collaboration with the FDA on this topic. As such, your Reference Committee recommends reaffirmation of existing policy.

Dietary Supplements and Herbal Remedies H-150.954
(1) Our AMA supports efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.
(2) Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.
(3) Our AMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.
(4) Our AMA will work with the FDA to educate physicians and the public about FDA's Safety Reporting Portal (SRP) and to strongly encourage

physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.

(5) Our AMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.

(6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:

(a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;

(b) dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;

(c) FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and

(d) regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers.

(7) Our AMA supports FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement.

(8) Our AMA will work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.

(9) Our AMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.

10) Our AMA strongly urges dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for the product labeling to:

(a) not include structure/function claims that are not supported by evidence from robust human studies;

(b) not contain prohibited disease claims;

(c) eliminate "proprietary blends" and list and accurately quantify all ingredients contained in the product;

(d) require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and

(e) include accurate and useful disclosure of ingredient measurement.

(11) Our AMA supports and encourages the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.

(12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on

adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.

(13) Our AMA will continue its efforts to educate patients and physicians about the risks associated with the use of dietary supplements and herbal remedies and supports efforts to increase patient, healthcare practitioner, and retailer awareness of resources to help patients select quality supplements, including educational efforts to build label literacy.

(22) RESOLUTION 512 - OPIOID OVERDOSE REVERSAL AGENTS WHERE AED'S ARE LOCATED

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that policy H-95.932 be reaffirmed in lieu of Resolution 512.

HOD ACTION: Resolution 512 adopted.

RESOLVED, that our American Medical Association support the expansion of naloxone availability through colocation of intranasal naloxone with AEDs in public locations. (New HOD Policy)

Your Reference Committee heard overwhelming positive testimony for expanded access to naloxone, and supportive of the intent of the proposed resolution. Other testimony noted implementation challenges of naloxone expiration and management of refilling used naloxone. However, your Reference Committee did not hear testimony describing how the proposed resolution differs from current policy of our AMA (subsection 8 of the policy below) and as such, your Reference Committee recommends reaffirmation.

Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications H-95.932

1. Our American Medical Association supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone and other safe and effective overdose reversal medications delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone and other safe and effective overdose reversal medications.
3. Our AMA encourages physicians to co-prescribe naloxone and other safe and effective overdose reversal medications to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone and other safe and effective overdose reversal medications on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications to receive appropriate education to enable them to do so effectively.

7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone and other safe and effective overdose reversal medications with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone and other safe and effective overdose reversal medications in all public spaces regardless of whether the individual holds a prescription.
10. Our AMA supports efforts to increase the availability, delivery, possession and use of mail-order overdose reversal medications, including naloxone, to help prevent opioid-related overdose, especially in vulnerable populations, including but not limited to underserved communities and American Indian reservation populations.

Madam Speaker, this concludes the report of Reference Committee E. I would like to thank Carl Streed, Jr, MD, Catriona Hong, Vivek Rao, MD, Kenath Shamir, MD, Charles Van Way, MD, Erin Schwab, MD, and all those who testified before the Committee.

Carl Streed, Jr, MD (Alternate)
GLMA Health Professionals Advancing LGBTQ Equality

Catriona Hong (Alternate)
Connecticut

Vivek Rao, MD (Alternate)
Texas

Kenath Shamir, MD (Alternate)
Massachusetts

Charles Van Way, MD
Missouri

Erin Schwab, MD
Colorado

Robert Panton
Illinois
Chai

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-24)

Report of Reference Committee F

Rebecca L. Johnson, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 4 - AMA 2025 Dues
2. Board of Trustees Report 21 - American Medical Association Meeting Venues and Accessibility
3. Board of Trustees Report 23 - United States Professional Association for Transgender Health Observer Status in the House of Delegates
4. Board of Trustees Report 26 - Equity and Justice Initiatives for International Medical Graduates
5. Board of Trustees Report 28 - Encouraging Collaboration Between Physicians and Industry in AI Development
6. Board of Trustees Report 33 - Employed Physicians
7. Report of the House of Delegates Committee on Compensation of the Officers
8. Speakers' Report 1 - Report of the Resolution Modernization Task Force Update
9. Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 - Joint Council Sunset Review of 2014 House Policies
10. Council on Long Range Planning and Development Report 1 - Establishment of a LGBTQ+ Section
11. Resolution 602 - Ranked Choice Voting
12. Resolution 609 - Standardization of the Endorsement Process

RECOMMENDED FOR ADOPTION AS AMENDED

13. Board of Trustees Report 25 - Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences Resolution 605 - Walking the Walk of Climate Change
14. Board of Trustees Report 35 - Mitigating the Cost of Medical Student Participation in AMA Meetings
15. Resolution 601 - Annual Holocaust Remembrance Event
16. Resolution 604 - Confronting Ageism in Medicine
17. Resolution 606 - Creation of an AMA Council with a Focus on Digital Health Technologies and AI
18. Resolution 608 - The American Medical Association Diversity Mentorship Program

RECOMMENDED FOR ADOPTION IN LIEU OF

19. Resolution 603 - End Attacks on Health and Human Rights in Israel and Palestine
Resolution 610 - Opposition to Collective Punishment

RECOMMENDED FOR NOT ADOPTION

20. Resolution 607 - Appealing to our AMA to Add Clarity to its Mission Statement to Better Meet the Need of Physicians, the Practice of Medicine and the Public Health

RECOMMENDED FOR FILING

21. Board of Trustees Report 1 - Annual Report
22. Board of Trustees Report 27 - AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates

Amendments
If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 4 - AMA 2025 DUES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 4 be <u>adopted</u> and the remainder of the Report be <u>filed</u>.

HOD ACTION: Recommendation in Board of Trustees Report 4 <u>adopted</u> and the remainder of the Report <u>filed</u>.

The Board of Trustees recommends no change to the dues levels for 2025, that the following be adopted and that the remainder of this report be filed:

Regular Members	$420
Physicians in Their Fourth Year of Practice	$315
Physicians in Their Third year of Practice	$210
Physicians in Their Second Year of Practice	$105
Physicians in Their First Year of Practice	$60
Physicians in Military Service	$280
Semi-Retired Physicians	$210
Fully Retired Physicians	$84
Physicians in Residency/Fellow Training	$45
Medical Students	$20

(Directive to Take Action)

Dues pricing is routinely evaluated to ensure that the membership value proposition is optimized through enhancing the AMA's membership benefits portfolio.

Online Forum testimony was limited. The following editorial change will be made for a editorial error that appears in the report:

> The Board of Trustees recommends no change to the dues levels for ~~2024~~ <u>2025</u>, that the following be adopted and that the remainder of this report be filed:

Beyond a statement from the AMA Board of Trustees, no in-person testimony was provided. Your Reference Committee recommends that Board of Trustees Report 4 be adopted.

(2) BOARD OF TRUSTEES REPORT 21 - AMERICAN MEDICAL ASSOCIATION MEETING VENUES AND ACCESSIBILITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 21 be adopted and the remainder of the Report be filed.

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

The Board therefore recommends Policy G-630.140 be reaffirmed and is strictly enforced as a resolute stance against all forms of discrimination, and support of evidenced-based medicine, underscoring our commitment to fostering an inclusive and safe environment for all attendees. This strategic recommendation places a primary emphasis on prioritizing attendee safety, reflecting the values and principles upheld by the AMA.

Testimony in response to Board of Trustees Report 21 was generally supportive. The Medical Student Section (MSS) highlighted that current Policy G-630.140 negatively impacts MSS regional meetings. Prior to the pandemic, some regions were limited in their ability to host in-person meetings due to site limitations in states that were in violation of AMA policy. The MSS supports amendment to the fourth clause of Policy G-630.140 to include adding the term "national"; thereby, allowing MSS regional meetings to occur without compromising the anti-discrimination stance for national events.

Your Reference Committee anticipated recommending that Board of Trustees Report 21 be amended to reflect the requested change to AMA Policy G-630.140; however, our Board of Trustees recommendation to reaffirm policy does not open the current policy for an amendment. To amend AMA Policy G-630.140, a resolution specific to that policy would need to be introduced.

Therefore, your Reference Committee recommends adoption of Board of Trustees Report 21 as written.

(3) BOARD OF TRUSTEES REPORT 23 - UNITED STATES PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH OBSERVER STATUS IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 23 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 23 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the United States Professional Association for Transgender Health be admitted as an Official Observer in the House of Delegates, and that the remainder of this report be filed.

Your Reference Committee received limited but supportive testimony in response to this item of business. Your Reference Committee favors adoption of Board of Trustees Report 23 and looks forward to welcoming our colleagues from the United States Professional Association for Transgender Health.

(4) BOARD OF TRUSTEES REPORT 26 - EQUITY AND JUSTICE INITIATIVES FOR INTERNATIONAL MEDICAL GRADUATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 26 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 26 adopted and the remainder of the Report filed.

The Board of Trustees recommends that Resolution 605-A-23 not be adopted and that the remainder of the report be filed.

Testimony provided by the Board of Trustees indicated that this report was written to offer clarity on whether the AMA, through the Center for Health Equity, will incorporate an annual session focused on international medical graduates (IMGS) into the equity forum. Further, this report addresses whether the AMA should, through the Center for Health Equity, amend the health equity plan to address the issues of equity and justice for international medical graduates.

The recommendation in Board of Trustees Report 26 is based on the following: "to permanently designate a particular topic or group over others would be counterproductive to the ideals of fairness and equity and risks the possibility of harm, creating an atmosphere of resentment and discouragement among those who may feel excluded or unfairly treated." As AMA policy requires an equity forum at least once a year, each meeting presents an opportunity to provide education on a variety of topics including, but not limited to, issues impacting IMGs

Testimony indicated that the IMG Section have since engaged in productive conversations with the Board of Trustees and the Center for Health Equity on opportunities to create awareness and provide education on issues of concern.

Your Reference Committee recommends adoption of Board of Trustees Report 26.

(5) BOARD OF TRUSTEES REPORT 28 - ENCOURAGING COLLABORATION BETWEEN PHYSICIANS AND INDUSTRY IN AI DEVELOPMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 28 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 28 adopted and the remainder of the Report filed.

The Board of Trustees recommends that Resolution 609-A-23 not be adopted and that this report be filed.

The AMA Board of Trustees provided an overview of the report, noting that the AMA has various existing initiatives, research, policy, advocacy efforts, educational material and other resources that are aligned with the desire to boost physician-centered innovation in the field of AI research and development. As such, much of the work that Resolution 609-A-23 asks the AMA to conduct is already ongoing.

Limited Online Forum testimony was supportive of the Board of Trustees Report and noted appreciation for AMA efforts to ensure physician input in various aspects of AI development in health care.

Your Reference Committee recommends adoption of Board of Trustees Report 28.

(6) BOARD OF TRUSTEES REPORT 33 - EMPLOYED PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 33 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 33 adopted and the remainder of the Report filed.

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

That AMA policy D-405.969 be rescinded as having been accomplished by this report (Rescind HOD Policy).

Testimony provided by the Board of Trustees indicates that this report was written as an update to Board of Trustees Report 9-I-22. The employed physician caucus created by the Organized Medical Staff Section (OMSS) was identified as the most appropriate means for providing a voice to employed physicians within the AMA. Board of Trustees Report 33 further describes the establishment and activity of the OMSS-convened employed physician caucus.

Limited testimony noted that the employed physician caucus convened at the 2024 Annual meeting.

Further, this report accomplishes AMA policy D-405.969 and calls for this policy be rescinded. Your Reference Committee recommends adoption of Board of Trustees Report 33.

(7) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in the Report of the House of Delegates Committee on the Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in the Report of the House of Delegates Committee on the Compensation of the Officer adopted and the remainder of the Report filed.

The Committee on Compensation of the Officers recommends the following recommendation be adopted and the remainder of this report be filed:

1. That the secretarial reimbursement be increased to $1,125 effective January 1, 2025.

2. That there be no changes to Officers' compensation for the period beginning July 1, 2024 through June 30, 2025.

3. That the remainder of the report be filed.

Beyond the introduction of the Report of the House of Delegates Committee on the Compensation of the Officers, no further testimony was received.

Your Reference Committee extends its appreciation to the committee for the report and agrees with the proffered recommendations.

(8) SPEAKERS REPORT 1 - REPORT OF THE RESOLUTION MODERNIZATION TASK FORCE UPDATE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendations in Speakers Report 1 be <u>adopted</u> and the remainder of the Report be <u>filed</u>.

HOD ACTION: Recommendations in Speakers Report 1 <u>adopted as amended by addition</u> and the remainder of the Report <u>filed</u>.

1. **The bylaws be amended so that the resolution submission deadline be 45 days prior to the Opening Session of the House of Delegates <u>with AMA Sections excluded from this deadline</u>. (Directive to Take Action)**

2. **The bylaws be amended so that the definition of a late resolution shall be all resolutions submitted after the resolution submission deadline <u>with AMA Sections excluded from the deadline</u> and prior to the beginning of the Opening Session of the House of Delegates. (Directive to take Action)**

The Resolution Modification Task Force recommends that the following be adopted to be implemented for Interim 2024 and the remainder of the report be filed:

1. The bylaws be amended so that the resolution submission deadline be 45 days prior to the Opening Session of the House of Delegates. (Directive to take Action)

2. The bylaws be amended so that the definition of a late resolution shall be all resolutions submitted after the resolution submission deadline and prior to the beginning of the Opening Session of the House of Delegates. (Directive to take Action)

3. The bylaws be amended so that the definition of an emergency resolution shall be all resolutions submitted after the beginning of the Opening Session of the House of Delegates. (Directive to take Action)

4. The bylaws be amended so that the term of committees of the House of Delegates shall commence upon their formation and shall conclude at the end of the meeting for which they were appointed, unless otherwise directed by the House of Delegates. (Directive to take Action)

5. That our AMA will convene Online Reference Committee Hearings prior to each House of Delegates meeting. These hearings shall open 10 days following the resolution submission deadline and remain open for 21 days. This shall be accomplished in lieu of Policy G-38 600.045. (New HOD Policy)

6. Prior to House of Delegates meetings, reference committees will convene after the close of the Online Reference Committee Hearings to develop a Preliminary Reference Committee Report. These reports shall include preliminary recommendations and will serve as the agenda for the in-person reference committee hearing. This shall be accomplished in lieu of Policy G-600.060(8). (New HOD Policy)

7. That Policy D-600.956 be rescinded. (Rescind HOD Policy)

Testimony was generally supportive of the Speakers' Report 1 noting that similar process contributed to an enhanced policymaking experience within their medical societies. However, there were mixed sentiments regarding some of the report recommendations.

Testimony expressed concern that Recommendation 1, which calls for a resolution submission deadline of 45 days prior to the Opening Session of the House of Delegates, could disenfranchise our AMA Sections and some medical societies from partaking in the resolution process.

Testimony on Recommendation 2 was mixed. Recommendation 2 calls for a Bylaws amendment redefining late resolutions. There was concern that this change would create hurdles for having resolutions considered by the House of Delegates. Other Online Forum participants expressed support for this proposed change.

Recommendation 6 calls for the development of a Preliminary Reference Committee Report, which will include preliminary recommendations that will serve as the agenda for the in-person reference committee hearing. Supportive comments indicated that the Preliminary Reference Committee Report would create an opportunity for more robust testimony and mitigate barriers to presenting testimony on various items. Opposing commentary expressed concern that an anchoring bias could be introduced, repetitive statements would be presented online and in-person, and reference committee recommendations may not reflect the totality of testimony. It was further noted that focus on the onsite reference committee hearings could shift to debating the recommendations in the Preliminary Reference Committee Report, rather than the policy issues.

Although various amendments were proffered, your Reference Committee heard the appeal of the Speaker and the Resolution Modernization Task Force to try the new process first and make future adjustments as needed. The Speaker provided reassurance that resolutions would receive fair consideration in light of the timing for their resolution development processes.

Based on the testimony provided, your Reference Committee recommends that Speakers' Report 1 be adopted.

(9) COUNCIL ON CONSTITUTION AND BYLAWS/COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - JOINT COUNCIL SUNSET REVIEW OF 2014 HOUSE POLICIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendation in Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Beyond introduction of the Councils on Constitution and Bylaws and Long Range Planning and Development Report 1 by the author, no other testimony was received.

Your Reference Committee recommends adoption of the Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1.

(10) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - ESTABLISHMENT OF A LGBTQ+ SECTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendations in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

The Council on Long Range Planning and Development recommends that the following recommendations be adopted and the remainder of the report be filed:

1. That our American Medical Association transition the Advisory Committee on Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) Issues to the LGBTQ+ Section as a delineated section. (Directive to Take Action)

2. That our AMA develop bylaw language to recognize the LGBTQ+ Section. (Directive to Take Action)

There was limited but supportive testimony for the Council on Long Range Planning and Development Report 1.

Your Reference Committee extends its appreciation to the council for its comprehensive report, and your Reference Committee is pleased to have a role in facilitating the creation of a new AMA Section that will serve to represent LGBTQ+ issues.

(11) RESOLUTION 602 - RANKED CHOICE VOTING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 602 be adopted.

HOD ACTION: Resolution 602 adopted.

RESOLVED, that our American Medical Association study ranked choice voting for all elections within the House of Delegates. (Directive to Take Action)

Testimony on the proposed study of ranked choice voting for AMA elections generated a mixed response. Those opposed indicated there is minimal evidence that the current system is problematic. Further testimony indicated that ranked choice voting may not eliminate the need for runoff elections in every scenario.

For the reasons elucidated by the testimony, your Reference Committee believes a study would be beneficial to understanding the implications of potentially migrating to a new voting process; therefore, your Reference Committee favors adoption of Resolution 602 for the purpose of securing the requested study.

(12) RESOLUTION 609 - STANDARDIZATION OF THE ENDORSEMENT PROCESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 609 be adopted.

HOD ACTION: Resolution 609 adopted.

RESOLVED, that our American Medical Association require all groups that endorse candidates turn in information about their endorsement process, the deadline, and a staff contact for applications in a timely and streamlined manner (New HOD Policy); and be it further

RESOLVED, that our AMA then post this information on the election website in a timely manner, with the information being easily digestible and accessible (Directive to Take Action); and be it further

RESOLVED, that our AMA not allow any group that fails to provide this information in a timely manner to offer an endorsement during that election cycle (New HOD Policy); and be it further

RESOLVED, that our AMA create a specific period (similar to virtual elections) during which endorsements may be sought. (New HOD Policy)

Your Reference Committee received limited testimony in response to Resolution 609, but was positively influenced by testimony calling for parity among candidates with varying degrees of administrative support.

Your Reference Committee therefore recommends that Resolution 609 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(13) BOARD OF TRUSTEES REPORT 25 - ENVIRONMENTAL SUSTAINABILITY OF AMA NATIONAL MEETINGS. SUPPORTING CARBON OFFSET PROGRAMS FOR TRAVEL FOR AMA CONFERENCES RESOLUTION 605 - WALKING THE WALK OF CLIMATE CHANGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 25 be amended by addition and deletion to read as follows:

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 603-A-23 and 608-A-23, and that the remainder of the report be filed:

1. **Our AMA is committed to progression to net zero emissions for its business operations by 2030, by continuing and expanding energy efficiency upgrades, waste reduction initiatives, and the transition to renewable energy sources (New HOD Policy).**

2. **Our AMA will prioritize sustainable organizational practices to reduce emissions ~~over purchasing carbon offsets~~ (New HOD Policy).**

3. **Our AMA Board of Trustees will present a report at the 2024 Interim Meeting that details a timeline as to when and how to achieve our organizational carbon neutrality. (Directive to Take Action)**

~~3~~4. **Our AMA will continue to prioritize collaboration within the health care community by sharing the learnings from our sustainability initiative to inspire our peer organizations to follow suit and adopt similar environmentally conscious practices (Directive to Take Action).**

5. **Our AMA will work with appropriate entities to encourage the United States healthcare system to decrease emissions to half of 2010 levels by 2030, achieve net zero by 2050, and remain net zero or negative (Directive to Take Action).**

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 25 be adopted as amended in lieu of Resolution 605 and the remainder of the Report be filed.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Board of Trustees Report 25 be changed to read as follows:

ENVIRONMENTAL SUSTAINABILITY OF AMA NATIONAL MEETINGS

HOD ACTION: Recommendations in Board of Trustees Report 25 adopted as amended in lieu of Resolution 605 and the remainder of the Report filed with a changed title.

ENVIRONMENTAL SUSTAINABILITY OF AMA NATIONAL MEETINGS

Board of Trustees Report 25
The Board of Trustees recommends that the following be adopted in lieu of Resolutions 603-A-23 and 608-A-23, and that the remainder of the report be filed:

1. Our AMA is committed to progression to net zero emissions for its business operations by 2030, by continuing and expanding energy efficiency upgrades, waste reduction initiatives, and the transition to renewable energy sources (New HOD Policy).

2. Our AMA will prioritize sustainable organizational practices to reduce emissions over purchasing carbon offsets (New HOD Policy).

3. Our AMA will continue to prioritize collaboration within the health care community by sharing the learnings from our sustainability initiative to inspire our peer organizations to follow suit and adopt similar environmentally conscious practices (Directive-to-Take-Action).

Resolution 605
RESOLVED, that our American Medical Association Board of Trustees present to the House of Delegates at Interim 2024 a detailed timeline as to when and how to achieve our organizational carbon neutrality (Directive to Take Action); and be it further

RESOLVED, that our AMA staff study AMA-related corporate travel with respect to minimizing carbon emissions and/or mitigating or off-setting such emissions (Directive to Take Action); and be it further

RESOLVED, that our AMA adopt a policy for plant-based menus as the default option when planning meeting venues with an opt-out alternative as appropriate. (Directive to Take Action)

Testimony in response to Board of Trustees Report 25 was generally supportive and suggested that the report addresses the issues raised in Resolution 605; however, some who testified believe that the report did not devote sufficient discussion and consideration to purchasing carbon offsets and this should not be overlooked, which is the basis for the amendment by deletion in Recommendation 2.

Your Reference Committee received testimony that the third Resolve contained in Resolution 605 to offer plant-based menus as the default option was not widely accepted. Your Reference Committee notes that our AMA meeting registration allows accommodations for dietary restrictions.

Finally, testimony was supportive of additional recommendations calling for plan transparency by the 2024 Interim Meeting, as well as actionable goals for our AMA to lead by example in promoting environmental stewardship.

(14) BOARD OF TRUSTEES REPORT 35 - MITIGATING THE COST OF MEDICAL STUDENT PARTICIPATION IN AMA MEETINGS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 35 be <u>amended by addition and deletion</u> to read as follows:

3. That our AMA will explore alternate mechanisms to provide financial assistance to facilitate attendance at MSS meetings with a report back ~~in A-26~~ <u>at the 2025 Annual Meeting</u>.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 35 be <u>adopted as amended</u> and the remainder of the Report be <u>filed</u>.

HOD ACTION: Recommendations in Board of Trustees Report 35 <u>adopted as further amended by deletion</u> and the remainder of the Report <u>filed</u>.

~~4. That AMA policy G-615.103 (4) be rescinded.~~

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

1. That our AMA will promote the value of membership and meeting attendance to encourage financial support by medical schools and other funding sources.

2. That our AMA will explore mechanisms to mitigate the cost of meeting attendance for medical students.

3. That our AMA will explore alternate mechanisms to provide financial assistance to facilitate attendance at MSS meetings with a report back in A-26.

4. That AMA policy G-615.103 (4) be rescinded.

Testimony presented by our AMA Board of Trustees indicated that while AMA has made available additional travel funding in the two years since the adoption of the policy directing this report, alternatives for funding student travel costs need to be further explored and needs to consider factors such as potential tax implications for the AMA and for medical students, as well as critical ties between medical students and their Federation organizations. Our Board indicated more time is needed to fully research medical student funding options, and our Board acknowledged the urgency expressed by the testimony by agreeing to an earlier report back to be presented at the 2025 Annual Meeting.

Your Reference Committee believes our Board of Trustees should be allowed the time needed to make a informed decision that is in the best interest of our AMA and our medical student meeting participants.

(15) RESOLUTION 601 - ANNUAL HOLOCAUST REMEMBRANCE EVENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 601 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association provide educational materials ~~host an annual event~~ in support of International Holocaust Remembrance Day (January 27) ~~to provide education~~ to physicians and ~~medical~~ trainees about the role of physicians in the Holocaust, and other human rights atrocities, and the role this played in developing the current Code of Medical Ethics. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 601 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 601 be changed to read as follows:

HOLOCAUST REMEMBERANCE

HOD ACTION: Resolution 601 adopted as amended with a changed title.

HOLOCAUST REMEMBERANCE

RESOLVED, that our American Medical Association host an annual event in support of International Holocaust Remembrance Day (January 27) to provide education to medical trainees about the role of physicians in the Holocaust. (Directive to Take Action)

Testimony offered by the resolution author stated that "medical involvement in the Holocaust has profoundly influenced contemporary medical ethics." It was noted that history is not generally prioritized in medical education, and a limited number of medical schools allow curricular time to learn about the role of physicians in the Holocaust and its implications.

Although testimony was overwhelmingly supportive of the intent of Resolution 601, there was some disagreement on the implementation of an Annual Holocaust Remembrance Event. Thus, the Texas Delegation proffered an amendment:

> RESOLVED, that our American Medical Association encourage education for all physicians and learners by supplying information on ~~host an annual event in support of~~ International Holocaust Remembrance Day (January 27) in reference to the participation ~~to provide education to medical trainees about the role~~ of physicians in the Holocaust and the role this played in developing the current code of medical ethics, with a goal of preventing this from happening again. (Directive to Take Action)

While the resolution author was supportive of the Texas amendment, reception for the amended language was mixed noting that a curriculum schedule change may not be required as asynchronous learning is commonplace. Some Online Forum participants shared that an AMA produced event could be recorded as a resource for medical schools, residency programs, and continuing medical education.

Other Online Forum participants noted support for the intent of the Texas amendment and one in particular indicated that additional educational resources, including a webinar, could be produced for additional learning on this history and its relevance for today and for the future.

Testimony also noted that this education should incorporate other human rights atrocities such as the U.S. Public Health Service Untreated Syphilis Study at Tuskegee. Additional testimony indicated that the Holocaust was the foundation for the Declaration of Helsinki, which provides a statement of ethical principles for medical research involving human subjects.

Based on testimony, your Reference Committee recommends that Resolution 601 be adopted as amended.

(16) RESOLUTION 604 - CONFRONTING AGEISM IN MEDICINE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 604 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA will review ~~all existing policy~~ and amend policies regarding discrimination, bias and microaggressions, and add age or ageism ~~if not already mentioned~~ during the sunset review process (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 604 be adopted as amended.

HOD ACTION: Resolution 604 adopted as amended.

RESOLVED, that our American Medical Association adopt the following definition of ageism based on the World Health Organization (WHO) and AGE Platform Europe: "Ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age; structural ageism is the way in which society and its institutions sustain ageist attitudes, actions or language in laws, policies, practices or culture" (New HOD Policy); and be it further

RESOLVED, that our AMA establish a definition of "age equity," and consider adoption of the AGE Platform Europe vision: "Age equity is an inclusive society, based on well-being for all, solidarity between generations and full entitlement to enjoy life, participate in and contribute to society. At the same time, each person's rights and responsibilities throughout their life course have to be fully respected" (Directive to Take Action); and be it further

RESOLVED, that our AMA review all existing policy regarding discrimination, bias and microaggressions, and add age or ageism if not already mentioned (Directive to Take Action); and be it further

RESOLVED, that our AMA routinely incorporate intersectional approaches to ageism (Directive to Take Action); and be it further

RESOLVED, that our AMA conduct ongoing (1) advocacy for hospital and regulatory policy changes focused on individual physicians' care quality data rather than their age; and (2) educational outreach to AMA members (i.e. starting with a Prioritizing Equity episode panel discussion to be posted on Ed Hub™ for CME, as a video and podcast, and promoted through the UCEP/GCEP channels) (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the World Medical Association (WMA) and other interested stakeholders to have AMA's work significantly inform the global health organization's work on ageism. (Directive to Take Action)

Supportive testimony noted that ageism is an important issue impacting physicians from various age groups and concurred that this topic should be included in AMA efforts related to diversity, equity, and inclusion.

The third Resolve calls for a review of all existing policy regarding discrimination, bias and microaggressions, and add age or ageism. Testimony noted that the existing sunset review process can be used while lowering the significant fiscal note.

Based on testimony, your Reference Committee recommends that Resolution 604 be adopted as amended.

(17) RESOLUTION 606 - CREATION OF AN AMA COUNCIL WITH A FOCUS ON DIGITAL HEALTH TECHNOLOGIES AND AI

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 606 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association establish a task force by I-24 ~~define and propose a new AMA council~~ focused on digital health, technology, informatics, and augmented/artificial intelligence with the potential to transition this task force to a council~~, whose members shall be elected by the House of Delegates, for presentation and constitution at the 2025 Annual Meeting~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 606 be adopted as amended.

HOD ACTION: Resolution 606 adopted as further amended by addition and deletion.

RESOLVED, that our American Medical Association establish a task force by I-24 ~~define and propose a new AMA council~~ focused on digital health, technology, informatics, and augmented/artificial intelligence with ~~the potential to~~ transition of this task force to a new council and report back A-25 on this transition~~, whose members shall be elected by the House of Delegates, for presentation and constitution at the 2025 Annual Meeting~~. (Directive to Take Action)

RESOLVED, that our American Medical Association define and propose a new AMA council focused on digital health, technology, informatics, and augmented/artificial intelligence, whose members shall be elected by the House of Delegates, for presentation and constitution at the 2025 Annual Meeting. (Directive to Take Action)

Testimony was mixed regarding this topic. Supportive testimony indicated that a centralized group of physicians is needed to consider the implications of digital health technology and inform AMA advocacy and activities. Those in opposition indicated that there are existing opportunities to convene members while minimizing fragmentation within the AMA. Varying perspectives were presented on the best avenue for this work (e.g., task force, ad hoc committee, existing AMA council, etc.).

During testimony, various questions related to the cost and composition of a new council were raised: selection process for committee members, size of committee, and level of staff support.

Your Reference Committee heard concern that our AMA needs to be more expeditious in its efforts to lead on this issue. Therefore, your Reference Committee recommends the establishment of a task force by the 2024 Interim Meeting with the potential to transition to a council so that efforts will be ongoing.

(18) RESOLUTION 608 - THE AMERICAN MEDICAL ASSOCIATION DIVERSITY MENTORSHIP PROGRAM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 608 be <u>amended by addition</u> to read as follows:

RESOLVED, that our American Medical Association establish a diversity mentorship program to connect volunteer mentors with residents, fellows, and medical student mentees who are underrepresented in medicine (Directive to Take Action); and be it further
<u>RESOLVED, that the AMA encourages state, county, and specialty medical societies to develop mentorship programs that encourage people from under-represented groups to pursue careers in medicine (Directive to Take Action).</u>

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 608 be <u>adopted as amended</u>.

HOD ACTION: Resolution 608 <u>adopted as amended</u>.

RESOLVED, that our American Medical Association establish a diversity mentorship program to connect volunteer mentors with residents, fellows, and medical student mentees who are underrepresented in medicine. (Directive to Take Action)

Testimony was overwhelmingly supportive of Resolution 608 and commended the authors for bringing forward this resolution. Many of those testifying shared their experiences and concurred that mentorship plays an important role in supporting medical students and reaffirms the AMA's commitment to diversity, equity, and inclusion. It was further noted that a mentorship program focused on diversity in medicine will enhance the educational experience for students from historically marginalized backgrounds and nurture a health care environment that is inclusive and equitable for physicians and patients.

An additional Resolve clause was proffered to broaden the resolution's scope:

> RESOLVED, that the AMA encourages state, county, and specialty medical societies to develop mentorship programs that encourage people from underrepresented groups to pursue careers in medicine.

A similar amendment was submitted during the Online Forum testimony. Your Reference Committee favored the in-person amendment and recommends that Resolution 608 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(19) RESOLUTION 603 -END ATTACKS ON HEALTH AND HUMAN RIGHTS IN ISRAEL AND PALESTINE
RESOLUTION 610 - OPPOSITION TO COLLECTIVE PUNISHMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 603 be adopted in lieu of Resolution 603 and Resolution 610.

RESOLVED, that our AMA supports peace in Israel and Palestine in order to protect civilian lives and healthcare personnel (New HOD Policy); and be it further

RESOLVED, that our AMA supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict (New HOD Policy); and be it further

RESOLVED, that our AMA reaffirm AMA Policy D-65.993, War Crimes as a Threat to Physicians' Humanitarian Responsibilities. (Reaffirm HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 603 be changed to read as follows:

PROTECTION OF HEALTHCARE AND HUMANITARIAN AID WORKERS IN ALL AREAS OF ARMED CONFLICT

HOD ACTION: Alternate Resolution 603 adopted in lieu of Resolution 603 and Resolution 610 with a changed title.

PROTECTION OF HEALTHCARE AND HUMANITARIAN AID WORKERS IN ALL AREAS OF ARMED CONFLICT

Resolution 603
RESOLVED, that our American Medical Association supports a ceasefire in Israel and Palestine in order to protect civilian lives and healthcare personnel. (New HOD Policy)

Resolution 610
RESOLVED, that our American Medical Association (AMA) oppose collective punishment tactics—including restrictions on access to food, water, electricity, and healthcare—as tools of war; and be it further

RESOLVED, that our AMA oppose the use of United States funding to any entities that (1) do not uphold international law; or (2) commit or condone war crimes; and be it further
RESOLVED, that our AMA condemn the use of United States resources to enforce collective punishment on civilians, including in Gaza; and be it further

RESOLVED, that our AMA advocate for federal funding and support for national and international agencies and organizations that provide support for refugees, such as the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Reliefs and Works Agency for Palestinian Refugees in the Near East (UNRWA).

Testimony in response to Resolutions 603 and 610 was collegial, passionate, and mixed.

Those in support stated:

- Our AMA should advocate for protecting patients and healthcare workers in conflict zones.
- Our AMA plays a role in global health and human rights.
- Physicians have a responsibility to speak against war and its impacts on health.
- Our AMA needs to recognize the importance of addressing the United States' role in funding the conflict and its impact on healthcare.
- Our AMA featured an article calling for a ceasefire in the Ukraine in April 2022.

Those opposed indicated:

- The issue is beyond our AMA's purview; focus on issues relevant to our mission.
- Our AMA should not engage in geopolitical issues, which could divide the membership and have no tangible impact.
- The resolutions divert resources and credibility from our AMA's core issues.
- The AMA is a member of the World Medical Association, which issued a resolution on the protection of healthcare in Israel and Gaza in April 2024.

Your Reference Committee agrees with testimony indicating that our AMA should support the safety of healthcare and humanitarian aid workers, along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict.

Your Reference Committee recommends reaffirmation of AMA Policy D-65.993, War Crimes as a Threat to Physicians' Humanitarian Responsibilities, which addresses the concerns raised in testimony.

> Our AMA will (1) implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime, episodes of civil strife, or sanctions and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs, and (3) advocate for the protection of physicians' rights to provide ethical care without fear of persecution.

RECOMMENDED FOR NOT ADOPTION

(20) RESOLUTION 607 - APPEALING TO OUR AMA TO ADD CLARITY TO ITS MISSION STATEMENT TO BETTER MEET THE NEED OF PHYSICIANS, THE PRACTICE OF MEDICINE AND THE PUBLIC HEALTH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 607 not be adopted.

HOD ACTION: Resolution 607 not adopted.

RESOLVED, that our American Medical Association amends its mission's statement from "to promote the art and science of medicine and the betterment of public health" to "to empower physicians to better care for their patients, advance the art and science of medicine, and promote the betterment of physicians and the public health." (Directive to Take Action)

Testimony in response to Resolution 607 was generally opposed, and the authors indicated referral for study would be acceptable; however, your Reference Committee does not believe a study would overcome the opposing sentiment indicating that:

- the current mission statement is short and to the point;
- mission statements do not drive membership; and
- promoting physicians above others might be viewed negatively.

Your Reference Committee therefore recommends that Resolution 607 not be adopted.

RECOMMENDED FOR FILING

(21) BOARD OF TRUSTEES REPORT 1 - ANNUAL REPORT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 1 be filed.

HOD ACTION: Board of Trustees Report 1 filed.

The Consolidated Financial Statements for the years ended December 31, 2023 and 2022 and the Independent Auditor's report have been included in the 2023 Annual Report. This is included in the Handbook mailing to members of the House of Delegates and will be discussed at the Reference Committee F hearing.

Our AMA Board of Trustees highlighted activities related to the AMA Recovery Plan, namely physician burnout and prior authorization, along with the 2023 consolidated financial results. Our Board of Trustees noted that the financial condition of our AMA remains strong with having a reserve portfolio of one billion dollars, which is crucial to preserving the short- and long-term viability of the Association.

Your Reference Committee recommends that the 2023 Annual Report be filed.

(22) BOARD OF TRUSTEES REPORT 27 - AMA REIMBURSEMENT OF NECESSARY HOD BUSINESS MEETING EXPENSES FOR DELEGATES AND ALTERNATES

RECOMMENDATION:

Madam Speaker, your Reference Committee Recommends that Board of Trustees Report 27 be filed.

HOD ACTION: Board of Trustees Report 27 adopted as amended by addition of a recommendation.

RECOMMENDATION
The AMA Board of Trustees, with input from Federation medical society physicians and staff members, will present a comprehensive report at I-24 that presents options for reducing the costs of meetings and mechanisms to provide financial support (including reimbursement of necessary business expenses or grants) for Delegates and Alternate Delegates who are credentialed to participate in our House of Delegates.

At the 2023 Annual Meeting of the AMA House of Delegates (HOD) Resolution 606, “AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates” was referred to the Board of Trustees for a report back to the HOD. The reference committee heard mixed testimony, including compelling testimony from the Board of Trustees regarding their fiduciary responsibility to our AMA and the need to allow sufficient time to identify and fully assess the impact on our AMA.

Board of Trustees Report 27 indicates that the AMA will continue to study options for strengthening state and specialty society participation in House of Delegates meetings. Testimony voiced concerns over budget constraints impacting participation and potential equity issues as some may be excluded due to lack of financial support.

While the Board of Trustees empathized with these concerns, it noted that this issue is complex given potential legal and financial implications. Matters under consideration encompass criteria to determine need-based support, development of a reimbursement process in lieu of payment to attend HOD meetings, and alternative options for participation.
The Board of Trustees requested additional time to explore appropriate solutions to facilitate participation and present its findings in a report back to the House of Delegates at the 2025 Annual Meeting.

Your Reference Committee recommends that this informational Board of Trustees report be filed.

Madam Speaker, this concludes the report of Reference Committee F. I would like to thank Brooks F. Bock, MD, Robyn F. Chatman, MD, MPH, Robert A. Gilchick, MD, MPH, Richard F. Labasky, MD, MBA, Brandi N. Ring, MD, MBA, Michael B. Simon, MD, MBA, and all those who testified before the Committee.

Brooks F. Bock, MD
American College of Emergency Physicians

Robyn F. Chatman, MD, MPH
Ohio

Robert A. Gilchick, MD, MPH
American College of Preventive Medicine

Richard F. Labasky, MD, MBA
Utah

Brandi N. Ring, MD, MBA
American College of Obstetricians and Gynecologists

Michael B. Simon, MD, MBA
American Society of Anesthesiologists

Rebecca L. Johnson, MD
Florida
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-24)

Report of Reference Committee G

Yasser Zeid, MD, URPS, FACOG, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT Report 30 - Proper Use of Overseas Virtual Assistants in Medical Practice
2. CMS Report 1 – Sunset Review of 2014 House Policies
3. CMS Report 6 – Economics of Prescription Medication Prior Authorization
4. Resolution 701 – Opposition to the Hospital Readmission Reduction Program
5. Resolution 706 – Automatic Pharmacy-Generated Prescription Requests
6. Resolution 707 – Alternative Funding Programs
7. Resolution 709 – Improvements to Patient Flow in the U.S. Healthcare System
8. Resolution 718 – Transparency at the Pharmacy Counter

RECOMMENDED FOR ADOPTION AS AMENDED

9. BOT Report 29 - Transparency and Accountability of Hospitals and Hospital Systems
10. CMS Report 5 – Patient Medical Debt
11. Resolution 702 – The Corporate Practice of Medicine, Revisited
12. Resolution 703 – Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation
13. Resolution 704 – Pediatric Readiness in Emergency Departments
14. Resolution 705 – 20 Minute Primary Care Visits
15. Resolution 708 – Medicolegal Death Investigations
16. Resolution 710 – The Regulation of Private Equity in the Healthcare Sector
17. Resolution 712 – Full Transparency – Explanation of Benefits
18. Resolution 714 – Automatic Downcoding of Claims
19. Resolution 716 – Impact of Patient Non-adherence on Quality Score
20. Resolution 719 – Support Before, During, and After Hospital Closure or Reduction in Services

RECOMMENDED FOR ADOPTION IN LIEU OF

21. Resolution 711 – Insurer Accountability When Prior Authorization Harms Patients
    Resolution 720 – The Hazards f Prior Authorization
22. Resolution 721 – Developing Physician Resources to Optimize Practice Sustainability
    Resolution 717 – Mentorship to Combat Prior Authorization

Amendments

If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOT REPORT 30: PROPER USE OF OVERSEAS VIRTUAL ASSISTANTS IN MEDICAL PRACTICE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 30 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 30 adopted and the remainder of the Report filed.

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

1. That Our American Medical Association (AMA) reaffirm the following policies
    a. H-385.951 – Remuneration for Physician Services
    b. H-180.944 – Plan for Continued Progress Toward Health Equity
    c. H-135.932 – Light Pollution: Adverse Health Effects of Nighttime Lighting (Reaffirm HOD Policy)
2. That Policy H-200.947 be amended to read as follows: "Our AMA: (1) supports the 15 concept that properly trained ~~overseas~~ virtual assistants, in the U.S. or overseas, are an acceptable way to staff administrative roles in medical practices; and (2) will ~~study and offer formal guidance for physicians on how best to utilize overseas virtual assistants to ensure protection of patients, physicians, practices, and equitable employment in communities served, in a manner consistent with appropriate compliance standards~~ create and publish educational materials for medical practices that offer formal guidance on how best to utilize virtual assistants to ensure protection of patients, physicians, virtual assistants and practices." (Modify Current HOD Policy).

Your Reference Committee heard supportive testimony on Board of Trustees Report 30. Testimony was unanimously supportive of the report as written, including from the authors of the original resolution on which the report was based. Specifically, testimony cited the improvement of the engagement of their staff and the overall benefit it provided to her clinic. Therefore, your Reference Committee recommends that the Recommendations in Board of Trustees Report 30 be adopted and the remainder of the report filed.

(2) CMS REPORT 1 – SUNSET REVIEW ON 2014 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendations in the Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

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

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard limited supportive testimony on Council on Medical Service Report 1. The Council accepted the editorial change to remove gendered language in the reviewed policies. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted, and the remainder of the report be filed.

(3) CMS REPORT 6 – ECONOMICS OF PRESCRIPTION MEDICATION PRIOR AUTHORIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Recommendations in Council on Medical Service Report 6 be adopted and the remainder of the report be filed.

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

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 725-A-23, and the remainder of the report be filed:

That our American Medical Association supports working with payers and interested parties to ensure that prior authorization denial letters include at a minimum:

a. a detailed explanation of the denial reasoning;
b. a copy of or publicly accessible link to any plan policy or coverage rules cited or used as part of the denial; and

c. what rationale or additional documentation would need to be provided to approve the original prescription and alternative options to the denied medication.

2. That our AMA amend Policy H-120.919 to read as follows:
That our AMA will: (1) continue to support efforts to publish implement a ~~Real-Time Prescription Benefit (RTPB)~~ Real-Time Benefit Tool (RTBT) standard that meets the needs of all physicians and other prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient; (2) support efforts to ensure that provider-facing and patient facing RTBT systems align; and (3) advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an ~~RTPB~~ RTBT standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish ~~RTPB~~ RTBT tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals; (4) advocate that RTBT systems provide a justification for why prior authorization is required and include approved/covered alternative prescription medications; ~~and~~ (~~3~~5) develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize ~~RTPB tools~~ RTBT and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment; (6) advocate that payers honor coverage information that is based on a RTBT at the time of prescription and that prior authorization approvals should be valid for the duration of the prescribed/ordered treatment; and (7) continue to advocate for the accuracy and reliability of data provided by RTBTs and for vendor neutrality to ensure that it is supportive to physician efforts. (Modify Current HOD Policy)

3. That our AMA Policy H-110.963, which addresses the regulation and monitoring of third-party Pharmacy Benefit Managers (PBMs) in an effort to control prescription drug pricing. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-125.979, which outlines advocacy efforts to ensure that physicians have access to real-time formulary data when prescribing. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-320.945, which details opposition to the abuse of prior authorization and the requirement for payers to accurately report denials and approvals. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-125.986, which outlines the AMA's position that certain actions from PBMs interfere with physician practice and may impact the patient-physician relationship. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-120.933, which encourages the gathering of data to better understand the impact that PBM actions may lead to an erosion of the patient-physician relationship. (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony on Council on Medical Service Report 6. Testimony indicated the importance of ensuring that information on prior authorization denials is available to patients and physicians, particularly to

prevent delays in care. A delegation indicated support for the report but recommended clarification that the Real-Time Benefit Tool systems should be uniform. Based on testimony your Reference Committee believes that the inclusion of "standard" adequately addresses this concern, and the addition of additional language would be redundant. Based on the supportive testimony heard for this report, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be adopted, and the remainder of the report be filed.

(4) RESOLUTION 701 – OPPOSITION TO THE HOSPITAL READMISSIONS REDUCTION PROGRAM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 701 be adopted.

HOD ACTION: Resolution 701 adopted.

RESOLVED, that our American Medical Association oppose the Hospital Readmissions Reduction Program. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 701. Delegations explained that the Hospital Readmissions Reduction Program (HRRP) is not supported by research and that the program has been linked with worse patient outcomes and increased readmissions. The Council on Medical Service testified that the removing of this program would require Congressional action and that this may not be the best use of AMA advocacy capital. However, compelling testimony was provided regarding the harm that the HRRP causes and therefore your Reference Committee recommends the adoption of Resolution 701.

(5) RESOLUTION 706 – AUTOMATIC PHARMACY-GENERATED PRESCRIPTION REQUESTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 706 be adopted.

HOD ACTION: Resolution 706 adopted.

RESOLVED, that Our American Medical Association advocates that pharmacy-generated requests for changes to a prescription (quantity dispensed, refills, or substitutions) clarify whether these requests are generated by the patient or patient's surrogates, or automatically by the pharmacy. (Directive to Take Action)

Your Reference Committee heard exclusively supportive testimony of Resolution 706. Multiple delegations testified to the importance of ensuring that physicians and patients have accurate information about prescriptions, including automatically generated refill

requests. Testimony reflected that these automatic refills have the potential to cause patient harm should a patient unintentionally take too much of a medication or for a duration longer than intended by the physician. Therefore, your Reference Committee recommends Resolution 706 be adopted.

(6) RESOLUTION 707 – ALTERNATIVE FUNDING PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 707 be adopted.

HOD ACTION: Resolution 707 adopted.

RESOLVED, that Our American Medical Association will educate employers, benefits administrators, and patients on alternative funding programs (AFPs) and their negative impacts on patient access to treatment and will advocate for legislative and regulatory policies that would address negative impacts of AFPs. (Directive to Take Action)

Your Reference Committee heard supportive testimony of Resolution 707. Multiple delegations indicated the significant harms that come from Alternative Funding Programs (AFPs). Specifically, testimony outlined that AFPs can cause significant delays in patients receiving medications, or in some cases prevent patients from accessing medications altogether. Your Reference Committee heard testimony suggesting referral of this item due to the complexity and novelty of AFPs. Additional concern was voiced that the AMA may not be the appropriate body to educate on this issue. However, a significant amount of testimony indicated the necessity of addressing this issue and explained that the AMA has similar ongoing education efforts on related drug pricing topics. Therefore, your Reference Committee believes that your AMA is the appropriate body to educate and advocate on this issue. Additionally, testimony reflected the urgency of this issue and the potential harm that could come if AMA action was delayed by referral of this resolution. Therefore, your Reference Committee recommends the adoption of Resolution 707.

(7) RESOLUTION 709 – IMPROVEMENTS TO PATIENT FLOW IN THE U.S. HEALTHCARE SYSTEM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 709 be adopted.

HOD ACTION: Resolution 709 adopted.

RESOLVED, that Our American Medical Association will work with relevant stakeholders and propose recommendations to appropriate entities to improve patient flow and access to care throughout multiple environments in the U.S. healthcare system. (Directive to Take Action)

Your Reference Committee heard testimony that was supportive of Resolution 709 and outlined that delayed patient flow throughout the U.S. health care system adversely affects patient care and can threaten optimal outcomes. Testimony for the referral of this item was heard from a few delegations, however, a number of delegations indicated that this issue is one of significant relevance and importance. Specifically, testimony indicated that efforts in this area are already underway and that the AMA has the opportunity to join a wide variety of stakeholders to improve patient flow in the health care system. Due to the supportive testimony, your Reference Committee recommends Resolution 709 be adopted.

(8) RESOLUTION 718 – TRANSPARENCY AT THE PHARMACY COUNTER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 718 be <u>adopted.</u>

HOD ACTION: Resolution 718 <u>adopted</u>.

Our American Medical Association advocates for legislation or regulation that mandates that pharmacies, whether physical or mail-order, must inform patients about their prescriptions, to include at a minimum:

1. The dosage and schedule of treatments as written by the prescriber
2. Any restriction or alteration of the prescriber's intent due to third party or pharmacy intervention, with the stated justification
3. Details of other avenues to obtain the original prescription, including out of pocket options, with comparative costs (Directive to Take Action).

Your Reference Committee heard supportive testimony on Resolution 718. Testimony explained the importance of ensuring that patients can access full information about their prescriptions when picking them up at the pharmacy. Additionally, testimony explained that patients are often not notified of prescription changes until they are at the pharmacy. Based on this testimony, your Reference Committee recommends the adoption of 718.

RECOMMENDED FOR ADOPTION AS AMENDED

(9) BOT REPORT 29 – TRANSPARENCY AND ACCOUNTABILITY OF HOSPITALS AND HOSPITAL SYSTEMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolved clause of Board of Trustees Report 29 be amended by addition to read as follows:

2. That the following policy statement be adopted to supersede Policy H-200.971, "Transparency and Accountability of Hospitals and Hospital Systems,":

1. Our American Medical Association supports and facilitates transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports to include periodic report back to the HOD with the first update to be given at A-25.

2. Our AMA will develop educational materials on the peer review process and advocate on behalf of doctors who have been subject to bad-faith peer review, including information about what constitutes a bad-faith peer review and what options physicians may have in navigating the peer review process.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 29 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 29 adopted as amended and the remainder of the report filed.

The Board of Trustees recommends:

The following policies be reaffirmed:
H-405.950, "Preserving the Practice of Medicine"
H-225.950, "Principles for Physician Employment"

H-225.952, “The Physician’s Right to Exercise Independent Judgement in All Organized Medical Staff Affairs”
H-230.965, “Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators”
H-435.942, “Fair Process for Employed Physicians”
H-375.962, “Legal Protections for Peer Review
D-375.987, “Effective Peer Review”
H-375.960, “Protection Against External Peer Review Abuses”

2. That the following policy statement be adopted to supersede Policy H-200.971, “Transparency and Accountability of Hospitals and Hospital Systems,”:
   a. The AMA supports transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports (New HOD Policy).
   b. The AMA will develop educational materials on the peer review process, including information about what constitutes a bad-faith peer review and what options physicians may have in navigating the peer review process (Directive to Take Action).
3. That the title of Policy H-200.971, “Transparency and Accountability of Hospitals and Hospital Systems,” be changed to:
   a. “Transparent Reporting of Physician Complaints Against Hospitals and Health Systems”
4. That the remainder of this report be filed.

Your Reference Committee heard supportive testimony on Board of Trustees Report 29. Testimony outlined the importance of this issue and the need to ensure that transparency in hospital complaint systems is improved. Additionally, testimony indicated that this is a method that could help to dissuade gender bias in hospital settings. Testimony indicated a desire to have the AMA provide legal defense for impacted physicians, however while the AMA is able to advocate on behalf of physicians, but is not able to provide legal defense to a physician. Finally, testimony indicated that AMA efforts should not only support but also facilitate efforts, and that physicians should be defended if they are subjected to bad-faith peer reviews. Therefore, your Reference Committee recommends that the recommendation in Board of Trustees Report 29 be adopted as amended and the remainder of the report be filed

(10) CMS REPORT 5 – PATIENT MEDICAL DEBT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Service Report 5 be amended by addition to read as follows:

2. That our AMA support innovative efforts to address medical debt for patients, including requirements to offer sliding-scale, interest-free payment plans before collection or litigation activities and public and private efforts to eliminate medical debt, such as purchasing debt with the intent of cancellation. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: recommends that council on medical service report 5 adopted as amended and the remainder of the report be filed.

2. That our AMA support innovative efforts to address medical debt for patients, including sliding-scale, interest-free payment plans before collection or litigation activities and public and private efforts to eliminate medical debt, such as purchasing debt with the intent of cancellation. (New HOD Policy)

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 710-A-23 and Resolution 712-A-23, and the remainder of the report be filed:

1) That our American Medical Association (AMA) encourage health care organizations to manage medical debt with patients directly, considering several options including but not limited to discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions. (New HOD Policy)

2) That our AMA supports innovative efforts to address medical debt for patients, including public and private efforts to eliminate medical debt. (New HOD Policy)

3) That our AMA support amending the Fair Debt Collection Practices Act to include hospitals and strengthen standards within the Act to provide clarity to patients about whether their insurance has been or will be billed, which would require

itemized debt statements to be provided to patients, thereby increasing transparency, and prohibiting misleading representation in connection with debt collection. (New HOD Policy)

4) That our AMA opposes wage garnishments and property liens being placed on low-wage patients due to outstanding medical debt at levels that would preclude payments for essential food and housing. (New HOD Policy)

5) That our AMA support patient education on medical debt that addresses dimensions such as:
   a. Patient financing programs that may be offered by hospitals, physicians offices, and other non-physician provider offices;
   b. The ramifications of high interest rates associated with financing programs that may be offered by a hospital, physician's office, or other non-physician provider's office;
   c. Potential financial aid available from a patient's hospital and/or physician's office; and
   d. Methods to reduce high deductibles and cost-sharing. (New HOD Policy)

Your Reference Committee heard testimony in support of Council on Medical Service Report 5. The authors of the resolutions that spurred the creation of this report supported Council on Medical Service Report 5 as written. There were a handful of amendments proposed and the Council defended their report recommendations as written. A delegation proffered an amendment to ensure that medical debt is not included in credit reports and the removal of the requirement that the debt level precludes payments for essential food or housing. However, the Council provided compelling testimony to defend these positions and explained that these qualifiers ensure that patients who can pay medical bills are held accountable while ensuring that no patient is denied basic necessities. Your Reference Committee found the following amendment compelling and recommends that it be incorporated into the report; "requirements to offer sliding-scale, interest-free payment plans before collection or litigation activities and", as well as "such as purchasing debt with the intent of cancellation." The Council was amendable to this amendment. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

(11) RESOLUTION 702 – THE CORPORATE PRACTICE OF MEDICINE, REVISITED

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 702 be amended by addition to read as follows:

Our American Medical Association will revisit the concept of restrictions on the corporate practice of medicine, including, but not limited to, private equities, hedge funds and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by Annual 2025 with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 702 be adopted as amended.

HOD ACTION: Resolution 702 adopted as amended.

RESOLVED, that our American Medical Association revisit the concept of restrictions on the corporate practice of medicine, including private equities, hedge funds and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report to our House of Delegates by Annual 2025 that will inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality healthcare, while containing healthcare costs. (Directive to Take Action)

Your Reference Committee heard supportive testimony of Resolution 702. One delegation highlighted a situation in which the number of physicians at a hospital was decreased due to the ownership by a private equity entity. The physicians went on strike and the private equity firm removed their ownership stake in the hospital as a result. One delegation proffered two amendments to expand the scope of the study requested by the resolution authors to include physician autonomy and increased transparency. Therefore, your Reference Committee recommends that Resolution 702 be adopted as amended.

(12) RESOLUTION 703 – UPHOLDING PHYSICIAN AUTONOMY IN EVIDENCE-BASED OFF-LABEL PRESCRIBING AND CONDEMNING PHARMACEUTICAL PRICE MANIPULATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 703 be amended by deletion to read as follows:

1. Our American Medical Association advocates for transparency, accountability, and fair pricing practices in pharmaceutical pricing.

2. Our AMA condemns interference with a physician's ability to prescribe clinically appropriate medication without risk of harassment, prosecution, or loss of their medical license, and calls on regulatory authorities to investigate and take appropriate action against such practices. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 703 be adopted as amended.

RECOMMENDATION D:

The Title of Resolution 703 be changed:

UPHOLDING PHYSICIAN AUTONOMY IN EVIDENCE-BASED OFF-LABEL PRESCRIBING

HOD ACTION: Resolution 703 adopted as amended with a title change.

RESOLVED, that our American Medical Association advocates for transparency, accountability, and fair pricing practices in pharmaceutical pricing, opposing differential pricing of medications manufactured by the same company with the same active ingredient, without clear clinical necessity (Directive to Take Action); and be it further

RESOLVED, that our AMA condemns interference with a physician's ability to prescribe one medication over another with the same active ingredient, without risk of harassment, prosecution, or loss of their medical license, and calls on regulatory authorities to investigate and take appropriate action against such practices. (New HOD Policy)

Your Reference Committee heard testimony in support of Resolution 703. Testimony was supportive of both resolved clauses, but primarily focused on the second resolved. The Council on Medical Service testified against opposing differential pricing in the first

resolved clause as this could have negative impacts on patient access to medication in some situations. An additional delegation indicated support for the Council's amendment as it negated potential issues with differential pricing in cases when it may be warranted due to the patient's diagnosis. The majority of testimony focused on the importance of ensuring that physicians have the autonomy to prescribe medications off-label when it is clinically appropriate and supported by evidence. Testimony indicated concern that only referring to the active ingredient in a medication may ignore differences in medication formulation beyond the active ingredient, however, this concern is addressed with the proffered amendment to refer to clinically appropriate medication. Finally, in order to ensure that the resolution title is an accurate reflection of the resolution itself, your Reference Committee recommends the adoption of Resolution 703 as amended with a title change.

(13) RESOLUTION 704 – PEDIATRIC READINESS IN EMERGENCY DEPARTMENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 704 be <u>amended by deletion</u> to read as follows:

RESOLVED, that our American Medical Association (AMA) work with appropriate state and national organizations to advocate for the development and implementation of ~~regional and/or state~~ pediatric-ready facility recognition programs.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 704 be <u>adopted as amended.</u>

HOD ACTION: Resolution 704 <u>adopted as amended</u>.

RESOLVED, that our American Medical Association reaffirm H-130.939 acknowledging the importance of pediatric readiness in all emergency departments with awareness of the guidelines for Pediatric Readiness in the Emergency Department and stand ready to care for children of all ages (Reaffirm HOD Policy); and be it further

Our American Medical Association will work with appropriate state and national organizations to advocate for the development and implementation of regional and/or state pediatric-ready facility recognition programs. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 704 outlining that pediatric needs are nuanced and must be addressed separately from adult needs. Further testimony highlighted that this initiative would be especially beneficial to rural areas as a voluntary recognition program. The Council on Medical Service suggested a friendly

amendment to strike “regional and/or state” in order to ensure that standards are predictable for those seeking recognition. The amendment was supported by the original authors of the resolution. Your Reference Committee recommends that Resolution 704 be adopted as amended.

(14) RESOLUTION 705 – 20 MINUTE PRIMARY CARE VISITS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 705 be <u>adopted</u>.

RECOMMENDATION B:

The Title of Resolution 705 be <u>changed</u>:

TIME-LIMITED DIRECT PATIENT CARE

HOD ACTION: Resolution 705 <u>adopted</u> with a <u>title change</u>.

Our American Medical Association will ask that the appropriate AMA Council to conduct a study of the adverse effects of direct patient care time limitations on the quality of care provided, as well as on patient and physician dissatisfaction, with a report back at the next AMA Annual Meeting. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 705. Several delegations provided testimony in support of the resolution and that this issue spans beyond impacting only primary care. The Council on Medical Service requested the authors of the original resolution provide more background information on what they would like to see in the requested study, as there was only one whereas clause included in the resolution, and the language in the resolved clause is vague. To ensure that the title of this resolution accurately reflects the broad scope of the resolution, a title change was proffered. Your Reference Committee recommends that Resolution 705 be adopted with a title change.

(15) RESOLUTION 708 – MEDICOLEGAL DEATH INVESTIGATIONS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolved clause of Resolution 708 be <u>amended by deletion</u> to read as follows:

1. Our American Medical Association supports the independent authority of physicians to provide accurate and transparent postmortem assessments and death investigation reporting in a manner free from undue influence.

RECOMMENDATION B:

Your Reference Committee recommends Resolution 708 be adopted as amended.

HOD ACTION: Resolution 708 adopted as amended.

RESOLVED, that our American Medical Association supports the independent authority of physicians practicing forensic pathology to provide accurate and transparent postmortem assessments and death investigation reporting in a manner free from undue influence (New HOD Policy); and be it further

2. Our AMA will advocate with state and federal governments to ensure laws and regulations do not compromise a physician's ability to use their medical judgement in the reporting of postmortem assessments and medicolegal death investigations.

Your Reference Committee heard overwhelmingly supportive testimony of Resolution 708. Testimony explained the importance of ensuring that physicians are not unduly influenced by external factors when participating in a postmortem assessment. A number of delegations testified that this concept is important not only for physicians practicing forensic pathology but also in other situations like pediatric and obstetric death investigations. Testimony from the original authors indicated support for broadening the resolution beyond only those practicing forensic pathology. Specifically, testimony indicated that influence may come in the form of politics or administration and that all physicians should be able to participate in postmortem assessment in a manner they feel is accurate and appropriate for the situation. Therefore, your Reference Committee recommends the adoption of Resolution 708 as amended.

(16) RESOLUTION 710 – THE REGULATION OF PRIVATE EQUITY IN THE HEALTHCARE SECTOR

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolved clause of Resolution 710 be amended by addition to read as follows:

1. Our American Medical Association will propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolved clause of Resolution 710 be amended by addition and deletion to read as follows:

4. Our AMA will work with state and federal government and other interested parties to develop and advocate for regulations pertaining to corporate control of practices in the healthcare sector such that physician autonomy in clinical care is preserved and protected.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 710 be adopted as amended.

HOD ACTION: Resolution 710 adopted as amended.

RESOLVED, that our American Medical Association propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy in clinical care is preserved and protected (Directive to Take Action); and be it further

RESOLVED, that our AMA modify policy H-215.981, Corporate Practice of Medicine, by addition:
4. Our AMA will work with the federal government and other interested parties to develop and advocate for regulations pertaining to the use of private equity in the healthcare sector such that physician autonomy in clinical care is preserved and protected. (Modify Current HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 710 and highlighted that private equity contracts with physicians often do not protect physician autonomy to make decisions regarding care for patients. There were three friendly amendments proposed to broaden the language and expand the resolution to cover all corporate practice of medicine entities, not just private equity firms. Therefore, your Reference Committee recommends that Resolution 710 be adopted as amended.

(17) RESOLUTION 712 – FULL TRANSPARENCY – EXPLANATION OF BENEFITS

RECOMMENDATION A:

Madam Speaker, your reference committee recommends that Resolution 712 be amended by addition and deletion to read as follows:

Our American Medical Association advocates that the minimum information included in an explanation of benefits, whether sent to the patient or the physician practice, includes the actual CPT codes billed, DRG-codes, CPT descriptions, and optional consumer-friendly descriptions; and EOB must list the actual allowed amount, patient responsibilities (copay, deductible, coinsurance), non-covered and denied amounts with specific X12 reason codes in consumer-friendly explanations, what criteria is used for coverage and non-coverage, and includes detailed explanation on how to appeal, including contact information for plan administrator, applicable laws governing the plan benefits, and contact information to submit external complaints, in a manner that protects patient privacy.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 712 be adopted as amended.

HOD ACTION: Resolution 712 adopted as amended.

RESOLVED, that our American Medical Association will advocate legislation and regulations that mandate that explanation of benefits, whether sent to the patient or the physician practice, including the actual CPT codes billed, DRG-codes, CPT descriptions, and optional consumer-friendly descriptions; and EOB must list the actual allowed amount, patient responsibilities (copay, deductible, coinsurance), non-covered and denied amounts with specific X12 reason codes in consumer-friendly explanations, what criteria is used for coverage and non-coverage, and includes detailed explanation on how to appeal, including contact information for plan administrator, applicable laws governing the plan benefits, and contact information to submit external complaints. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 712. The author testified that the resolution serves to modify the electronic standard for the Explanation of Benefits (EOB) and that paper EOBs should be subject to the same requirements as the electronic version. An individual testified that this information is critical in the fight against denials and underpayments, especially given how heavily billing is outsourced. The Council on Medical Service proffered an amendment to increase the actionability of this resolution. Testimony was supportive of the Council's amendment. Testimony was heard outlining potential concerns around patient privacy and ensuring that sensitive information was not shared on the EOB without patient consent. Accordingly, your Reference Committee recommends that Resolution 712 be adopted as amended.

(18) RESOLUTION 714 – AUTOMATIC DOWNCODING OF CLAIMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolved of Resolution 714 be amended by addition and deletion to read as follows:

1. Our American Medical Association vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the fourth Resolved of Resolution 714 be amended by addition and deletion to read as follows:

4. Our AMA will further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 714 be adopted as amended.
HOD ACTION: Resolution 714 adopted as amended.

2. Our AMA supports that, after review of the patient's medical record and determination that a lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes.

3. Our AMA will advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim.

Your Reference Committee heard testimony in support of Resolution 714. The authors testified that in recent years technology has been leveraged to automatically downcode simply based on a diagnosis code without viewing the patient record. One delegation

testified that downcoding is tantamount to the illegal practice of medicine. Additionally, several members testified with examples of how insurers' downcoding practices are arbitrary and capricious. Testimony stressed that insurers should be held accountable for downcoding practices. Your Reference Committee amended the resolved clause to accurately reflect all testimony heard. Testimony was received to amend the resolution to indicate a stronger stance against downcoding and to ensure that payers are not able to utilize a loophole of non-exclusive use of software and algorithms. Therefore, your Reference Committee recommends Resolution 714 be adopted as amended.

(19) RESOLUTION 716 – IMPACT OF PATIENT NON-ADHERENCE ON QUALITY SCORES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 716 be <u>amended by deletion</u> to read as follows:

Our American Medical Association will study the issue of patients and parents not adhering to physicians' recommendations such as preventive screenings and vaccinations resulting in a deficiency of quality metrics by physicians for which the physicians are penalized, identify equitable and actionable solutions, and report back at Annual 2025.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 716 be <u>adopted as amended.</u>

HOD ACTION: Resolution 716 <u>adopted as amended</u>.

RESOLVED, that our American Medical Association study the issue of patients and parents not adhering to primary care physicians' recommendations such as preventive screenings and vaccinations resulting in a deficiency of quality metrics by primary care physicians for which the physicians are penalized, identify equitable and actionable solutions, and report back at Annual 2025. (Directive to Take Action)

Your Reference Committee heard supportive testimony of Resolution 716. Testimony from delegations and individuals indicated the importance of ensuring physicians are not

penalized for patient decisions. However, a significant amount of testimony explained that this is an issue beyond primary care and amendments were proffered to expand the resolution to indicate that this problem persists in more than just primary care settings. Testimony explained that physicians should be allowed to present medical advice and then respect their patient's choices. Additionally, testimony outlined the importance of ensuring that reporting metrics are contextualized and do not unduly or inequitably impact physicians who are practicing medically appropriate care. Therefore, your Reference Committee recommends the adoption of Resolution 716 as amended.

(20) RESOLUTION 719 – SUPPORT BEFORE, DURING, AND AFTER HOSPITAL CLOSURE OR REDUCTION IN SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolved clause of Resolution 719 be <u>amended by addition</u> to read as follows:

1. Our American Medical Association will work with appropriate federal and state bodies to assure that whenever there is a threatened, or actual, hospital closure a process be instituted to safeguard the continuity of patient care and preserve the physician-patient relationship. Such a process should:
a. Assure adequate capacity exists in the immediate service area surrounding the hospital closure, including independent health resources, physicians, and support personnel to provide for the citizens of that area;
b. Allow that in said circumstances, restrictive covenants, records access, and financial barriers which prevent the movement of physicians and their patients to surrounding hospitals should be waived for an appropriate period of time
<u>c. Ensure financial reserves exist, and are sufficient to cover any previous contractual obligations to physicians, e.g., medical liability tail coverage.</u>

2. Our AMA will proactively offer support to physicians, residents and fellows, patients, and civic leaders affected by threatened or actual healthcare facility closures<u>, change in ownership,</u> or significant reductions in services via provision of information, resources, and effective, actionable advocacy.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 719 be adopted as amended.

HOD ACTION: Resolution 719 adopted as amended.

RESOLVED, that our American Medical Association will work with appropriate federal and state bodies to assure that whenever there is a threatened, or actual, hospital closure a process be instituted to safeguard the continuity of patient care and preserve the physician-patient relationship. Such a process should:

a) Assure adequate capacity exists in the immediate service area surrounding the hospital closure, including independent health resources, physicians, and support personnel to provide for the citizens of that area;

b) Allow that in said circumstances, restrictive covenants, records access, and financial barriers which prevent the movement of physicians and their patients to surrounding hospitals should be waived for an appropriate period of time (Directive to Take Action); and be it further

RESOLVED, that our AMA will proactively offer support to physicians, residents and fellows, patients, and civic leaders affected by threatened or actual healthcare facility closures or significant reductions in services via provision of information, resources, and effective, actionable advocacy. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 719. Specifically, delegations testified that this kind of support has been offered in certain states with success for both patients and physicians. Specifically, delegations offered examples of state support allowing physicians to negotiate for essential items such as medical liability tail coverage after a hospital closure or reduction in services. Testimony from delegations and individuals indicated support for amendments to outline assurances that employers have the resources necessary to meet contractual obligations with physicians and that the support be expanded to hospitals that are experiencing a change in ownership. Testimony explained that a hospital change in ownership can have many of the same negative impacts on physicians as a closure. To ensure that contractual obligations to physicians are met and that support is extended to hospitals experiencing ownership changes, your Reference Committee recommends the adoption of Resolution 719 as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(21) RESOLUTION 711 – INSURER ACCOUNTABILITY WHEN PRIOR AUTHORIZATION HARMS PATIENTS
RESOLUTION 720 – THE HAZARDS OF PRIOR AUTHORIZATION

RECOMMENDATION A:
Madam Speaker, your Reference Committee recommends that Resolution 711 be amended by addition to read as follows:

RESOLVED, that our American Medical Association advocate for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that amended Resolution 711 be adopted in lieu of Resolution 720.

HOD ACTION: Resolution 711 adopted in lieu of Resolution 720.

RESOLVED, that our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization (Directive to Take Action); and be it further

RESOLVED, that our AMA support that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization (New HOD Policy); and be it further

RESOLVED, that our AMA support that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care. (New HOD Policy)

Your Reference Committee heard testimony in favor of holding insurers accountable for patient harm caused by prior authorization. Several delegations testified to prior authorization causing care delays, adverse events, bottlenecks to access, costs to private practices and physician burnout, all noting that prior authorization is a hurdle to the practice of medicine and ultimately hurts patients. One individual testified how the unsustainable levels of prior authorization led them to abandon their sub-specialty. Other

testimony called out the current lack of legislative and regulatory teeth to combat these insurer practices. Your Reference Committee heard mixed testimony about combining Resolutions 711 and 720. The Council of Medical Service recommended adopting Resolution 711 in lieu of Resolution 720. The AMA has existing policies that cover the first and second resolve clauses of Resolution 720 which are related to prior authorization payment for and volume reduction. Testimony was received that Resolution 711 and the final resolved clause in Resolution 720 are exceptionally similar and sufficient to address the concerns at hand. A substitute resolution was proffered; however, it did not receive supportive testimony as it was said to be too general and already covered by AMA policy. Additionally, while supportive of the Resolution as a whole, there was mixed testimony as to the arbitration clause in Resolution 711 due to concerns about adverse consequences to physicians. An amendment was proffered to address this concern by specifying arbitration referenced is specific to prior authorization determinations. Overall, testimony was supportive of the amended Resolution 711 and indicated support for the intent of Resolution 720 but had concerns with the specifics. Therefore, your Reference Committee recommends that Resolution 711 be adopted as amended and in lieu of Resolution 720.

(22) RESOLUTION 721 – DEVELOPING PHYSICIAN RESOURCES TO OPTIMIZE PRACTICE SUSTAINABILITY
RESOLUTION 717 – MENTORSHIP TO COMBAT PRIOR AUTORIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 721 be <u>adopted in lieu of Resolution 717.</u>

HOD ACTION: Resolution 721 <u>adopted in lieu of Resolution 717.</u>

1. Our American Medical Association will develop a toolkit for physicians as a means to reduce excessive healthcare costs as well as improve physician practice sustainability and wellbeing, with a report back by Annual 2025.

2. Our AMA will study the development of a template for a mentorship program for early career physicians as a means to reduce excessive healthcare costs, with a report back by Annual 2025.

3. Our AMA will develop modules of education centered on the economics of utilization of testing, pharmaceuticals, and procedures in various categories of common and exceptional medical care.

4. Our AMA will work with affected stakeholders, including government legislators and regulators, pharmaceutical and business interests, healthcare systems, and patient representatives as well as physicians on substitution of mentorship for frequent prior authorization requests.

Your Reference Committee heard testimony outlining support for the development of resources for physicians to reduce healthcare costs and improve sustainability and wellbeing. While testimony was supportive of the concept of both Resolution 721 and 717, concern was expressed that the language of 717 was inappropriately focused only on early career physicians and that the focus should be broader. Additional concerns were expressed that the specificity of Resolution 717 could have adverse consequences. Specifically, a number of individuals testified to the potential that adopting Resolution 717 could indicate the AMA's approval or acknowledgement of the necessity of prior authorization. Your Reference Committee believes that Resolution 721 did not indicate support for prior authorization nor place the burden of excessive health care costs on physicians. In order to avoid these potential consequences, testimony overwhelmingly indicated support for the adoption of 721 instead of 717. Therefore, your Reference Committee recommends Resolution 721 be adopted in lieu of Resolution 717.

Madam Speaker, this concludes the report of Reference Committee G. I would like to thank Rosalynn Conic, MD, PhD, MPH, Janine Fogarty, MD, Peter Hollman, MD, AGSF, Robert Kramer, MD, FAAOS, Brian Privett, MD, Kim Yu, MD, FAAFP, and all those who testified before the Committee.

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