Ref Comm	Resolution/ Report	Title	Recommendation/Resolve	Support/Not Support/Monitor/ Comments
C&B	BOT Report 18	Expanding Protections of End-of-Life Care	In light of these considerations, the Board of Trustees Report 18 reaffirms H-295.825, Palliative Care and End-of-Life Care; H-70.915, Good Palliative Care; D-295.969, Geriatric and Palliative Care Training for Physicians; and recommends that alternate Resolution 722, "Expanding Protection of End-of-Life Care," be adopted in lieu of Resolution 722 and this report be titled "Expanding Palliative Care" and the remainder of this report be filed: Our American Medical Association: (1) recognizes that access to palliative care, including hospice, is a human right. (2) recognizes that palliative care is the comprehensive management and coordination of care for pain and other distressing symptoms, including physical, psychological, intellectual, social, psychosocial, spiritual, and the existential consequences of a serious illness, which improves the quality of life of patients and their families/caregivers and that palliative care evaluation and that palliative care treatments are patient-centered and family-oriented., emphasizing shared decision-making according to the needs, values, beliefs, and culture or cultures of the patient and their family or chosen family. (3) recognizes that palliative care can be offered in all care settings through a collaborative team approach involving all disciplines (e.g., physicians, nurses, social workers, spiritual care providers, therapists, pharmacists) and should be available at any stage of a serious illness from birth to advanced age and may be offered simultaneously with disease modifying interventions. (4) recognizes that hospice is a specific type of palliative care, reserved for individuals with a prognosis of six months or less who have chosen to forego most life-prolonging therapies, whereas palliative can be offered alongside curative or life-prolonging treatments at any stage of illness.	Support

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			(5) recognizes that palliative care differs from physician assisted suicide in that palliative care does not intentionally cause death. In fact, palliative treatments that relieve symptom distress have been shown in numerous studies to prolong life. (6) will work with interested state medical societies and medical specialty societies and vigorously advocate for broad, equitable access to palliative care, including hospice, to ensure that all populations, particularly those from underserved or marginalized communities have access to these essential services. (7) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for assisting in, referring patients to, or providing palliative care services, including hospice. Fiscal Note: Minimal – Less than $500	
C&B	**Res. 003 (Senior Physicians Section)**	On the Ethics of Human Lifespan Prolongation	RESOLVED, that our American Medical Association undertake an evaluation of the ethics of extension of the human lifespan, currently considered to be 120 years, with the goal of providing guidance and/or guidelines for clinical practice, research and potential regulatory challenges. (Directive to Take Action) Fiscal Note: Modest – between $1,000 - $5,000	Support
B	BOT Report 6	Health Technology Accessibility for Aging Patients – original resolution Res. 213-I-23, "Health Technology Accessibility for Aging Patients," sponsored by the Medical Student Section (MSS)	The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 213-I-23, and the remainder of the report be filed.: That our American Medical Association amend Policy H-480-937 by addition and the title be changed by addition. Policy H-480-937, ADDRESSING EQUITY IN TELEHEALTH AND HEALTH TECHNOLOGY (1) Our American Medical Association recognizes access to broadband internet as a social determinant of health. (2) Our AMA encourages initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis	Support

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			on programs designed with and for historically marginalized and minoritized populations. (3) Our AMA encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations. (4) Our AMA supports efforts to design and to improve the usability of existing electronic health record (EHR) and telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with other mental or physical disabilities. (5) Our AMA encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth. (6) Our AMA supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations. (7) Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth. (8) Our AMA opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians. (9) Our AMA will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.	

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			(10) Our AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details. (11) Our AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access. (Modify Current HOD Policy) Fiscal Note: Less than $500	
B	Res. 201 (Tennessee):	Boarding Patients in the Emergency Room	RESOLVED, that our American Medical Association immediately collaborate with stakeholders such as hospitals, insurance companies, CMS, and joint commission to resolve this issue (Directive to Take Action) RESOLVED, that our AMA advocate strongly for appropriate staffing ratios and appropriate care for patients and the emergency room and those admitted but still physically located in the emergency room to decrease patient harm and physician and nurse burnout. (Directive to Take Action) Fiscal Note: Modest – between $1,000 - $5,000	Support
B	**Res. 208 (Senior Physicians Section)**	Medicare Part B Enrollment and Penalty Awareness	RESOLVED, that our American Medical Association review the current penalties for declining Medicare Part B coverage with the Centers for Medicare and Medicaid Services (CMS), and advocate for changes to improve awareness of the risk and financial burdens associated with discontinuing coverage before reaching age 65 (Directive to Take Action) RESOLVED, that our AMA advocate to CMS for the creation of a comprehensive checklist for seniors approaching age 65 to facilitate Medicare enrollment and avoid gaps in insurance coverage or permanent increases in Part B premiums (Directive to Take Action) RESOLVED, that our AMA advocate for enhanced public awareness	Support

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			regarding the risks of not enrolling in Medicare Part B, and support making information about these risks more accessible and widely available to prevent lifetime penalties (Directive to Take Action) RESOLVED, that our AMA explore with AARP and other interested organizations a mechanism for auto enrollment in Medicare Part B for those who take Social Security benefits before age 65 that would include additional premium support for those making less than $1,000 in monthly Social Security benefits. (Directive to Take Action) Fiscal Note: Moderate – between $5,000 - $10,000	
B	Res. 215 (American College of Obstetricians and Gynecologists, South Dakota, American Academy of Dermatology Association, American Society for Dermatologic Surgery Association)	Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas	RESOLVED, that our American Medical Association advocate for increased federal and state funding for loan forgiveness for physicians who commit to practice and reside in rural and underserved areas for a meaningful period of time (Directive to Take Action) RESOLVED, that our AMA urge Congress and State legislatures to establish retention bonus programs for physicians who maintain practice in rural areas for extended periods, with increasing bonuses for longer commitments (Directive to Take Action) RESOLVED, that our AMA advocate for the expansion and sustainable funding of residency and graduate medical education slots in rural areas, as well as opportunities for exposure to rural health care such as through clinical rotations in rural areas, to increase the likelihood of physicians practicing in these communities after training. (Directive to Take Action) Fiscal Note: Modest – between $1,000 - $5,000	Support
B	Res. 219 (New York)	Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently	RESOLVED, that our American Medical Association advocate for making telehealth reimbursement permanent for Medicare and for all health insurance providers. (Directive to Take Action) Fiscal Note: Modest – between $1,000 - $5,000	Support

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C	CME Report 1	Medication Reconciliation Education	The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 805-I-23, Resolve 2, and the remainder of this report be filed: That our AMA: 1. Amend AMA Policy D-120.965 "Pharmacy Review of First Dose Medication" by addition of a new third clause to read as follows: 3. Our AMA a) recognizes that medication reconciliation is a multidisciplinary process and b) supports education of physicians-in-training about the physician's role and responsibilities in medication reconciliation and management within a physician-led team in relevant clinical settings, to minimize medical errors and promote patient safety and quality of care. 2. Amend AMA Policy D-120.965 with a change in title to read as follows: Medication Reconciliation to Improve Patient Safety 3. Reaffirm AMA Policy H-160.902 "Hospital Discharge Communications" Fiscal Note: $1,000	
J	Res. 812 (Michigan, American Academy of Physical Medicine and Rehabilitation, American Academy of Orthopaedic Surgeons)	Advocate for Therapy Cap Exception Process	RESOLVED, that our American Medical Association actively advocate for all health plans with therapy caps or thresholds to include an exception process. This process should, at a minimum, follow the Medicare standard for therapy cap exceptions, ensuring that patients can access the necessary services to restore functional abilities and enhance quality of life. (Directive to Take Action) Modest – between $1,000 - $5,000	Support
J	Res. 823 (Louisiana)	Reigning in Medicare Advantage - Institutional Special Needs	RESOLVED, that our American Medical Association add I-SNPs to its advocacy efforts related to Medicare Advantage plans (Directive to Take Action) RESOLVED, that our AMA advocate for increased policies, rules,	Support

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		Plans	and general oversight over I-SNPs (Directive to Take Action) RESOLVED, that our AMA advocate for an overall ban on facility-owned I-SNPs. (Directive to Take Action) Fiscal Note: Modest – between $1,000 - $5,000	
K	CSAPH 03	HPV-Associated Cancer Prevention	1. That our AMA amend policy H-440.872, "HPV-Associated Cancer Prevention" by addition and deletion to read as follows: 1. Our AMA (a) strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents or caregivers when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs. 2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public. 3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers. 4. Our AMA: (a) encourages the integration of HPV vaccination and ~~routine cervical~~ appropriate HPV-related cancer screening into all appropriate health care settings and visits, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups ~~that benefit most from preventive measures,~~ including but not limited to low-income and pre-sexually active populations, (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.	Support

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			5. Our AMA supports ~~will encourage~~ efforts by states ~~appropriate stakeholders to investigate means~~ to increase HPV vaccine availability and accessibility, and HPV vaccination rates through a combination of policies such as ~~by~~ facilitating administration of HPV vaccinations in community-based settings ~~including school settings~~ including local health departments and schools, reminder-based interventions, school-entry requirements, and requirements for comprehensive and evidence-based sexual education. ~~6. Our AMA will study requiring HPV vaccination for school attendance.~~ 6~~7.~~ Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination, according to ACIP recommendations, to people who are incarcerated for the prevention of HPV-associated cancers. 7. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines 8. Our AMA will encourage continued research into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; (b) the impact of broad opt-out provisions on HPV vaccine uptake; and (c) the impact of the COVID-19 pandemic and vaccine misinformation on HPV vaccine uptake. (Modify Current HOD Policy) 2. That our AMA adopt the following new HOD policy. IMMUNIZATON REQUIREMENTS Our AMA recognizes that immunization requirements, including those for school attendance, serve as a strong motivator for parents and families to immunize their children according to the schedule recommended by the Centers for Disease Control and Prevention. (New HOD Policy) 3. That our AMA reaffirm Policy H-440.970, "Nonmedical Exemptions from Immunizations. (Reaffirm HOD Policy) Fiscal Note: $5,000 - $10,000	

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K	Res. 902 (Women Physicians Section)	Advancing Menopause Research and Care	RESOLVED, that our American Medical Association advocate for increased funding for biomedical and public health research on perimenopause, menopause, and related chronic conditions (Directive to Take Action) RESOLVED, that our AMA support expanded training opportunities for medical students, residents, and other health professions trainees to improve care, treatment, and management services for perimenopause, menopause, and related chronic conditions (New HOD Policy) RESOLVED, that our AMA support efforts to increase awareness and education related to menopause, mid-life women's health and related conditions, treatment, and preventative services. (New HOD Policy) Fiscal Note: Modest – between $1,000 - $5,000	Support
K	**Res. 911 (Senior Physicians Section)**	Adequate Masking and HPV Education for Health Care Workers (including those over age 45)	RESOLVED, that our American Medical Association advocate for the provision of N-95 masks or equivalent be required for all HCWs (health care workers) and patients who have potential exposure to HPV (Directive to Take Action) RESOLVED, that our AMA promote education for medical professionals on the importance of HPV education and professional responsibilities in these procedures (Directive to Take Action) RESOLVED, that our AMA work with the Centers for Disease Control and Prevention (CDC), the Advisory Committee on Immunization Practices (ACIP) and the Occupational Safety and Health Administration (OSHA) along with other relevant stakeholders to address airborne transmission risks of HPV during surgical procedures and to prevent health care-related transmission. (Directive to Take Action) RESOLVED, that our AMA Media Relations Team publicize with a press release to make physicians aware of these new policies, including those outlined in H-440.872, HPV Associated Cancer	Support

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			Prevention. (Directive to Take Action) Fiscal Note: Modest – between $1,000 - $5,000	
K	**Res. 912 (Senior Physicians Section)**	Assuring Representation of Older Age Adults in Clinical Trials	RESOLVED, that our American Medical Association specifically advocate for inclusion of older patients (both men and women) by amending H-460.911 as follows: 1. Our American Medical Association advocates that: a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, age and ethnicity, ~~including consideration of pediatric and elderly populations,~~ to determine if proportionate representation of women and minorities including older adults and children if appropriate is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations. b. The FDA have a page on its web site that details the prevalence of minorities and women and older adults including those over age 75 in its clinical trials and its efforts to increase their enrollment and participation in this research. c. Resources be provided to community level agencies that work with those minorities, females, older adults including those over age 75 and other underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in healthcare. These minorities include Black Individuals/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans (Directive to Take Action) RESOLVED, that our AMA monitor the effectiveness of H-460.911 on an annual basis (Directive to Take Action) RESOLVED, that our AMA collaborate with AHRQ, FDA, NIH and other relevant stakeholders to increase public awareness and education on the topic of inclusivity in clinical trial participation (Directive to Take Action)	Support

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			RESOLVED, that our AMA specifically submit comments to the FDA on current proposed industry guidelines for inclusion of underrepresented populations in clinical trials1 by September 2025. (Directive to Take Action) Fiscal Note: Moderate – between $5,000 - $10,000	
K	**Res. 913 (Senior Physicians Section)**	Sexually Transmitted Infections are on the Rise in the Senior Population	RESOLVED, that our American Medical Association advocate and promote the U.S. Preventive Services Task Force (USPSTF) recommendations for STI screening through interested senior advocates such as AARP, specifically targeting chlamydia, gonorrhea, human immunodeficiency virus (HIV), HPV and syphilis, for the senior population who are not regularly screened (Directive to Take Action) RESOLVED, that our AMA continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in the development of practice guidelines for sexually transmitted diseases in the senior population (Directive to Take Action) RESOLVED, that our AMA offer CME education regarding best practices for reducing sexually transmitted disease (including oral cancer risks) in the senior population through the AMA's Ed Hub as a resource to guide the delivery of clinical preventative services. (Directive to Take Action) Fiscal Note: $80,454 - Contract with third parties to develop educational content for physicians.	Support