AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION (A-19)

Report of the Medical Student Section Reference Committee

Danny Vazquez, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 05 – Improving the Health and Safety of Consensual Sex Workers
2. Resolution 16 – Strengthening Standards for LGBTQ Education
3. Resolution 17 – Amending G-630.140, Lodging, Meeting Venues and Social Functions
4. Resolution 34 – The Effects of Employment Discrimination on the Health of Formerly Incarcerated Individuals
5. Resolution 38 – Development and Implementation of Recommendations for Responsible Media Coverage of Drug Overdoses
6. WIM/COLA Report A – Pregnancy and Secondhand Smoke
7. CHIT Report A – Net Neutrality
8. COLRP/CME Report A – Philanthropic Efforts
9. CEQM Report A – Mobile Health Care
10. CSI Report A – Therapeutic Potential of Psychedelics
11. CHIT/CEQM Report A – Advertising in EHRs
12. CME/CEQM Report A – Tuition Reimbursement
13. CGPH Report B – Epinephrine Auto-Injector Devices
14. COLRP Report A – Region Bylaws

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

15. Resolution 02 – Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water
16. Resolution 03 – Amending H-490.913, Smoke-Free Environments and Workplaces, and H-490.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing to Include E-cigarettes
17. Resolution 04 – Support for the Use of Psychiatric Advance Directives
18. Resolution 09 – Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Research IRB Training
19. Resolution 10 – Encouraging the Development of Multi-Languate, Culturally-Informed Mobile Health Applications
20. Resolution 11 – Reimbursement for Post-Exposure Protocol for Needlestick Injuries
21. Resolution 13 – Engaging Stakeholders for Establishment of Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools
22. Resolution 18 – Addressing Health Disparities through Improved Transition of Care from Pediatric to Adult Care
23. Resolution 20 – Ethical Use of Cadavers in Medical Education and Research
24. Resolution 23 – Transparency Improving Informed Consent for Reproductive Health Services

25. Resolution 24 – Support for Veterans Courts
26. Resolution 26 – Amendment to H-150.949, Healthy Food Options in Hospitals
27. Resolution 28 – Sunscreen Dispensers in Public Spaces as a Public Health Measure
28. Resolution 30 – Ensuring the Best In-School Care for Children with Sickle Cell Disease
29. Resolution 31 – Increasing Access to Gang-Related Tattoo Removal in Prison and Community Settings
30. Resolution 36 – Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems
31. Resolution 37 – Support Expansion of Good Samaritan Laws
32. Resolution 42 – Addressing the Racial Pay Gap in Medicine
33. Resolution 43 – Removing Sex Designation from the Public Portion of the Birth Certificate
34. Resolution 48 – Affirming the Right of Minors to Consent to Vaccinations
35. Resolution 50 – Request for Benzodiazepine-Specific Prescribing Guidelines for Physicians
36. Resolution 51 – Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented Persons
37. COLA Report A – Housing Modifications
38. CGPH Report A – Food Insecurity
39. COLA Report C – Driving Restriction Laws

RECOMMENDED FOR REFERRAL

40. Resolution 46 – Laying the First Steps Towards a Transition for a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation
41. CME Report A – Access for Medical Students with Disabilities
42. COLA Report B – Mandatory Reporting

RECOMMENDED FOR NOT ADOPTION

43. Resolution 08 – Investigating Acanthosis Nigricans for High-Risk Children and Adolescents
44. Resolution 39 – Support of Visual Aids Covered by Medicaid and Further Research in Proper Eye Care Practices
45. Resolution 44 – Promote Ultrasound as a Cost-Effective Measure in Diagnostic Imaging
46. Resolution 47 – Improving Accessibility of AMA-MSS Resolutions
47. Resolution 49 – Ensuring Fair Pricing of Drugs Developed with the United States Government
48. Resolution 52 – A Resolution to Encourage Recovery Homes to Implement Evidence-Based Policies Regarding Access to Medication Assisted Treatment (MAT) for Opioid Use Disorder

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

49. Resolution 01 – Integration of Team-Based Learning in U.S. Medical Education
50. Resolution 06 – Advocating for Standardization and Regulation of Outpatient Rehabilitation Facilities

51. Resolution 07 – Support for a National Single-Payer Health Program
52. Resolution 12 – Encouraging Mental Health First Aid in the Community
53. Resolution 14 – Integrating Immigrant Rights Training into Residency Education
54. Resolution 15 – Emergency Department Observation Units (EDOUs): A Step Towards Reducing Healthcare Costs
55. Resolution 19 – Strengthening AMA-MSS Collaborations with Allied Underrepresented Minority Student Organizations at the Local Chapter Level
56. Resolution 21 – Supporting a Minimum Age Limit for Tackle Football
57. Resolution 22 – Reducing Unnecessary Post-Operative Labs
58. Resolution 25 – Advocate for a Global Carbon Pricing System
59. Resolution 27 – Liver Transplant Guidelines Regarding Patients with a History of Psychiatric Disorders
60. Resolution 29 – Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities
61. Resolution 32 – Increased Coverage for HPV Vaccinations
62. Resolution 33 – Curtailing Greenhouse Gas Emissions to Net Zero in the Health Sector
63. Resolution 35 – Implementing a Standardized Patient Flag System in the Electronic Medical Record
64. Resolution 40 – Transgender and Intersex Care Training for School Health Professionals
65. Resolution 41 – Enhance Protections for Patients Seeking Help for Pedophilic Urges and the Physicians Treating Them
66. Resolution 45 – Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations

(1) RESOLUTION 05 – IMPROVING THE HEALTH AND SAFETY OF CONSENSUAL SEX WORKERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 05 be <u>adopted</u>.

Resolution 05 asks the AMA to recognize the adverse health outcomes of criminalizing consensual sex work and support legislation that advances the sex work industry towards decriminalization and legalization.

Testimony generally supported the spirit of Resolution 05, with reservation about the second resolve clause. In particular, some were concerned that decriminalization or legalization of sex work might not receive much support in the House of Delegates and would require MSS to outlay significant political capital with no guaranteed return, and that AMA's adoption of this policy position could generate unfavorable press coverage. We understand these concerns but believe that this issue is important enough to warrant that expenditure and that risk. Concerns also were expressed over the potentially far-reaching implications of the second resolve clause—particularly, that it might force the AMA into uncomfortable advocacy territory (i.e., supporting legislation not fully aligned with other AMA policy). We also understand this concern, but note that our AMA's advocacy efforts are informed by the full body of AMA policy, and that AMA leadership and management

have discretion to support or not support legislation as they deem to be in the best interest of the organization. We therefore recommend that Resolution 05 be adopted as proposed.

(2) RESOLUTION 16 – STRENGTHENING STANDARDS FOR LGBTQ MEDICAL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 16 be adopted.

Resolution 16 asks the AMA to amend existing policy H-295.878 as follows: Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include Lesbian, Gay, Bisexual, Transgender and Queer health issues in the basic science, clinical care, and cultural competency ~~curriculum~~ curricula for both undergraduate and graduate medical education; and (4) encourages the Liaison Committee on Medical Education (LCME), American Osteopathic Association (AOA), and Accreditation Council for Graduate Medical Education (ACGME) to periodically reassess the current status of curricula for medical student and residency education addressing the needs of ~~pediatric and adolescent~~ Lesbian, Gay, Bisexual, Transgender and Queer patients.

Resolution 16 had overwhelming testimony in support of adoption. Your Reference Committee agrees with testimony that not only is it important to include curriculum around cultural competency, basic science, and clinical care of LGBTQ populations – including adult LGBTQ patients—but that it is also crucial to periodically reassess the status of LGBTQ education. We recommend that Resolution 16 be adopted as submitted.

(3) RESOLUTION 17 – AMENDING G-630.140, LODGING, MEETING VENUES AND SOCIAL FUNCTIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 17 be adopted.

Resolution 17 asks the AMA to amend existing policy G-630.140 to specify that the restrictions listed in the policy apply only to national meetings. Resolution 17 asks the AMA to amend policy as follows: It is the policy of our AMA not to hold national meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender

identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify and exception to this policy.

We heard extensive testimony on this resolution, generally divided between those suggesting that the AMA ought to take a principled position despite the consequences for the organization, and those suggesting that the benefit of engaging medical students in "prohibited" states outweighs the harm of paring back the AMA policy. We agree with the latter position, noting in particular the significant barriers to participation in the AMA (e.g., financial, time, etc.) placed in the path of students in prohibited states, especially students of limited financial means. We also observe that testimony opposing the resolution appears to have ended as soon as the authors fully explained the situation that led them to write this resolution. For reference, Region 3 consists of six states, four of which are prohibited from holding meetings, due to discriminatory state policies which conflict with those of the AMA. Members from Region 3 have proposed this resolution in order to be granted an exception for AMA Region meetings, so their members are able to easily travel to business meetings and participate in MSS activities. For these reasons, we recommend that Resolution 17 be adopted as written.

(4) RESOLUTION 34 – THE EFFECTS OF EMPLOYMENT DISCRIMINATION ON THE HEALTH OF FORMERLY INCARCERATED INDIVIDUALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 34 be adopted.

Resolution 34 asks the AMA-MSS to support policies and practices that prevent employers from discriminating against formerly incarcerated individuals.

Testimony was largely in support of Resolution 34. Your Reference Committee believes that taking the step to "ban-the-box" on job applications is enough to drastically change the outcomes of discrimination against formerly incarcerated individuals. Your Reference Committee did question why this resolution was not made external, but agrees that introducing this at the MSS level first is a good step to eventually bring this to the HOD. For these reasons your Reference Committee recommends that Resolution 34 be adopted as submitted.

(5) RESOLUTION 38 – DEVELOPMENT AND IMPLEMENTATION OF RECOMMENDATIONS FOR RESPONSIBLE MEDIA COVERAGE OF DRUG OVERDOSES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 38 be adopted.

Resolution 38 asks the AMA to encourage the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage and portrayal of drug overdoses.

Your Reference Committee heard mixed testimony in support of Resolution 38. Testimony revealed that the authors utilized current AMA policy concerning media coverage of mass shootings to craft this resolution. Your Reference Committee believes this is novel policy and that it is important the AMA is a voice in working to help how substance use disorder is portrayed in the media. For these reasons your Reference Committee recommends that Resolution 38 be adopted.

(6) WIM/COLA REPORT A - PREGNANCY AND SECONDHAND SMOKE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in WIM/COLA Report A be adopted and that the remainder of the report be filed.

At the 2018 Interim meeting, the AMA-MSS referred for study Resolution 05 – "Inclusion of Pregnant Women in the Secondhand Smoke Driving Ban" which requests an amendment to Secondhand Smoke Policy H-490.910 (2) to include pregnant women. I-18 MSS Reference Committee received testimony in support of the spirit of this resolution, but harbored extensive concerns that this resolution unintentionally supports the criminalization of pregnant women who smoke, or pregnant women who are near secondhand smoke, and expressed concerns that Resolution 05 threatens the autonomy of pregnant women. The Committee on Women in Medicine and Committee of Legislation and Advocacy recommend that the proposed addition of "and pregnant women" to Resolution 05 not be adopted and the remainder of the report be filed.

Your Reference Committee heard no testimony on WIM/COLA Report A. We commend the authors on an excellent report and recommend adoption.

(7) CHIT REPORT A - NET NEUTRALITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in CHIT Report A be adopted and the remainder of the report be filed.

At the 2018 Interim meeting the AMA-MSS referred for study Resolution 06 – "Promoting Research into the Effects of Net Neutrality on Public Health" which asks the AMA to research the effects that the repeal of net neutrality rules will have on healthcare accessibility, health insurance, online health resources, electronic health records, telemedicine, and pharmaceutical company advertising. The Committee on Health Information Technology studied the recently changed Federal Communications Commission (FCC) regulations on net neutrality, explored its financial and market competition ramifications, and researched its possible effects on medicine and public

health. The Committee recommends that Resolution 06 be adopted and remainder of the report be filed.

Your Reference Committee heard limited testimony on CHIT Report A. Region 1 asked that the recommendations include an explicit statement that the AMA support the reinstitution of net neutrality, but we do not believe that request falls within the scope of this report. The report was thorough and well-researched. We support the recommendations of this report.

(8) COLRP/CME REPORT A - PHILANTHROPIC EFFORTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in COLRP/CME Report A be adopted and the remainder of the report be filed.

At the 2018 MSS Interim meeting, the MSS passed Resolution 29 – "Understanding Philanthropic Efforts to Address Medical School Tuition" which asks the AMA-MSS to study the financial sustainability of factors enabling the implementation of tuition-free and tuition-reduced undergraduate medical education programs and that the AMA-MSS study the efficacy of using tuition-free and tuition-reduced undergraduate medical education programs to incentivize primary care specialty choice among medical students. After adoption, the Governing Council asked the Committee on Long Range Planning and Committee on Medical Education to conduct the studies and write this report. The Committee on Long Range Planning and the Committee on Medical Education recommend that the AMA-MSS continue to study this topic to gain a better understanding of the sustainability of free and reduced medical tuition programs and of the efficacy of these programs in effecting medical specialty choice and that the AMA-MSS regularly track tuition reimbursement programs across medical schools to monitor outcomes, and that the remainder of this report be filed.

We heard no testimony on COLRP/CME Report A and recommend that the recommendations in this report be adopted.

(9) CEQM REPORT A - MOBILE HEALTH CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in CEQM Report A be adopted and the remainder of the report be filed.

At the 2018 MSS Interim meeting, the AMA-MSS referred Resolution 28 for study, which asks the AMA-MSS to study mobile medical units as a means of delivering healthcare to underserved communities. There was mixed testimony heard on the original resolution at the I-18 meeting. Concern was noted that the AMA should not create extensive policy on paramedicine as our policy should focus on functioning of physicians and not other medical practices. Amendments were made to address these concerns, however the Reference Committee found merit in the AMA-MSS further studying the issue. The

Committee on Economics and Quality in Medicine studied this issue and recognizes the research on mobile medical units and recommends that the remainder of this report be filed.

Your Reference Committee heard no testimony on CEQM Report A. We appreciate the research done by the authors and we support the recommendation of this report.

(10) CSI REPORT A - THERAPEUTIC POTENTIAL OF PSYCHEDELICS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in CSI Report A be adopted and the remainder of the report be filed.

At the 2018 MSS Interim meeting, the AMA-MSS referred Resolution 17 – "Supporting Research into the Therapeutic Potential of Psychedelics" for study. Resolution 17 asks the AMA to call for the status of psychedelics as Schedule 1 substances be reviewed with the global facilitating clinical research and developing psychedelic-based medicines, explicitly support and promote research into the therapeutic potential of psychedelics to help make a more conducive environment for research, and support and promote research to determine the consequences of long-term psychedelic use. There was mixed testimony received and it was ultimately recommended that this not be adopted. The topic was then referred for study to the Committee on Scientific Issues who offered the following recommendations: That our AMA calls for the status of psychedelics as Schedule 1 substances be reclassified into a lower schedule class with the goal of facilitating clinical research and developing psychedelic-based medicines; That, given the high regulatory and cultural barriers, our AMA explicitly support and promote research into the therapeutic potential of psychedelics to help make a more conducive environment for research; and That our AMA supports and promotes research to determine the benefits and adverse effects of long-term psychedelic use.

The limited testimony heard on CSI Report A was in support. Your Reference Committee agrees with the recommendations in this report and supports that they be adopted.

(11) CHIT/CEQM REPORT A - ADVERTISING IN EHRS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in CHIT/CEQM Report A be adopted and the remainder of the report be filed.

At the 2018 Annual meeting, the AMA-MSS referred for study Resolution 06 – "Pharmaceutical Advertising in Electronic Health Record Systems" which asks the AMA to oppose the presence of pharmaceutical advertising including, but not limited to, digital banner placement, instant messaging, and pop-up ads within the electronic health record (EHR) to influence or attempt to influence, through economic incentives or otherwise, the prescribing decision of a prescribing practitioner at the point of care and that AMA support

legislation banning pharmaceutical advertising in electronic health record (EHR) systems. The MSS Governing Council assigned this topic to the Committee on Health Information Technology (CHIT) and the Committee on Economics and Quality in Medicine (CEQM) to study the current state of pharmaceutical advertising in EHR systems and the revenue models that currently exist for pharmaceutical advertising in EHRs. These Committees also looked at current AMA policy on pharmaceutical advertising and existing data on the effects of direct-to-physician advertising at the point of care on physician decision making, quality, and cost of care to determine if additional policy is needed. The CHIT and CEQM committees recommend that the following be adopted in lieu of A-18 MSS Resolution 06 and the remainder of the report be filed:

1. That our AMA encourage the Center for Medicare and Medicaid Services to study the effects of direct-to-physician advertising at the point of care, including advertising in EHRs, physician prescribing, patient safety, health care costs, and EHR access for small practices.

2. That our AMA study the ethics of direct-to-physician advertising at the point of care, including advertising in electronic health record systems.

There was no testimony heard on CHIT CEQM Report A. Your Reference Committee agrees with the recommendations and recommends that they be adopted.

(12) CME/CEQM REPORT A - TUITION REIMBURSEMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in CME/CEQM Report A be adopted and that the remainder of the report be filed.

At the 2018 Annual meeting MSS Resolution 34 asked the AMA to collaborate with stakeholders to study, develop, and implement a system for medical school tuition reimbursement for electronic medical record/electronic health record (EMR/EHR) documentation. The AMA-MSS assembly determined there may be unintended consequences on medical education and referred the resolution for study to the Committee on Medical Education (CME) and the Committee on Economics and Quality in Medicine (CEQM). CME and CEQM performed an analysis of current tuition payment options available to medical students, regulation of these payments, consequences to medical education from the proposed policy change, and feasibility of enacting these changes. CME and CEQM recommended that Resolution 34 not be adopted and the remainder of the report be filed.

Your Reference Committee heard no testimony on CME/CEQM Report A. We thank the authors for an informative report, including the significant ethical questions posed by the potential unintended consequences of the proposed policy, and recommend adoption.

(13) CGPH REPORT B - EPINEPHRINE AUTO-INJECTOR DEVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in CGPH Report B be adopted and the remainder of the report be filed.

At the 2018 Interim meeting, the AMA-MSS referred for study MSS Resolution 33 – "Encouraging Stocking Epinephrine Auto-Injector Devices at Restaurants" which asks the AMA to support the stocking of epinephrine auto-injector devices in standard first aid kits in food service establishments, and that AMA policy D-440.392 be amended to include language to encourage restaurants to keep epinephrine auto-injector devices in their standard first aid kit and encourage having employees trained in the signs of anaphylaxis. Concern was noted that this would be ineffective without training employees. Cost and feasibility were also a concern. After completing further study on this topic, CGPH concluded that there is not enough existing research to justify policy change to support mandatory stocking of auto-injectors in first aid kits and training of employees at food service establishments on the national scale. With the moderate fiscal note and unknown effect or cost of implementing the policy, this resolution should be kept in mind as it is on the frontier of first aid, along with Stop the Bleed programs, but it is too early to say what impact it will have moving forward. Because of this, the Committee on Global and Public Health recommends that Resolution 33 not be adopted and that this research is recognized and the remainder of the report be filed.

There was no testimony heard for CGPH Report B. Your Reference Committee thanks the authors for the work done on this report and recommends that the recommendations presented be adopted.

(14) COLRP REPORT A - REGION BYLAWS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in COLRP Report A be adopted and the remainder of the report be filed.

In the COLRP Report A-A-17, the MSS Committee on Long Range Planning (COLRP) assessed each Region's bylaws to determine if they were in compliance with the minimum standards set forth in GC Report D, A-15. Additionally, COLRP re-evaluated the bylaws of each MSS Region in an attempt to better understand similarities and differences between regions. The A-17 report recommended: 1) In alignment with MSS policy 665.012MSS, COLRP recommends the following: (a) That our MSS Speaker and Vice Speaker monitor all MSS Regions to ensure compliance with the minimum requirements in GC Report D, A-15; and (b) That our MSS COLRP re-evaluate the accordance of each Region's bylaws with the categories in Tables 1-5b and release its findings in an informational report to the Assembly at A-19. The report identifies how each region bylaw addresses the following categories: quorum, voting, parliamentary procedure, and policy coordination. In alignment with MSS policy 665.012MSS COLRP recommends: 1) That

our MSS Speaker and Vice Speaker monitor all MSS Regions to ensure compliance with the minimum requirements in GC Report D, A-15, and; 2) That Region 1 modify their bylaws to specify the selection of the Regional Delegate and the responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4; and 3) That Region 2 modify their bylaws to specify the responsibilities of the Region Delegation Chair and Region Chair and specify the selection of the Regional Delegate to be in accordance with MSS IOP 8.4, MSS IOP 8.1.3 and MSS IOP 8.3 respectively; and 4) That Region 3 modify their bylaws to specify the selection of the Regional Delegate and responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4; and 5) That Region 4 modify their bylaws to include the process in which the Region Chair, Region Delegates, and Region Delegation Chair are selected and the responsibilities of the Region Delegation Chair and Region Chair to be in accordance with MSS IOP 8.1.3 and MSS IOP 8.4; and 6) That Region 5 modify their bylaws to include details on the process in which the Region Delegation Chair and Region Delegate is selected and the responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.3 and MSS IOP 8.4; and 7) That Region 6 modify their bylaws to include details on the process in which the Region Delegation Chair and Region Delegate is selected and the responsibilities of the Region Delegation Chair and Region Chair, and eliminate the exclusion where the Region Delegation Chair cannot be an Alternate Delegate to be in accordance with MSS IOP 8.1.3, MSS IOP 8.3 and MSS IOP 8.4; and 8) That Region 7 modify their bylaws to describe the Region Chair responsibilities and the selection and responsibilities of the Region Delegation Chair to be in accordance with MSS IOP 8.1.3 and MSS IOP 8.4; and 9) That MSS-COLRP reevaluate the accordance of each Region's bylaws with the categories in Tables 1-5b and release its findings in an informational report to the Assembly at A-21; and 10) The remainder of this report be filed.

There was no testimony heard for COLRP Report A. Your Reference Committee thanks the authors for the clear review and summary of each Region's bylaws in a systematic manner using uniform criteria. The method used was sound and your Reference Committee recommends that the recommendations in COLRP Report A be adopted.

(15) RESOLUTION 02 – HEALTH IMPACT OF PER- AND POLYFLUOROALKYL SUBSTANCES (PFAS) CONTAMINATION IN DRINKING WATER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 02:

HEALTH IMPACT OF PER- AND POLYFLUOROALKYL SUBSTANCES (PFAS) CONTAMINATION IN DRINKING WATER

RESOLVED, That our AMA support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of Per- and Polyfluoroalkyl substances.

Resolution 02 asks the AMA to urgently call on the Environmental Protection Agency and the United States government to establish national enforceable maximum contaminant levels for Per- and Polyfluoroalkyl Substances (PFAS) in national primary drinking water and supporting legislation regarding the mitigation and regulation of Per- and Polyfluoroalkyl Substances in drinking water; call on the United States Government to establish national goals to ensure that there is blood level screening set at the 95th percentile based on the National Health and Nutrition Examination Surveys and eliminate Per- and Polyfluoroalkyl Substances exposures to pregnant women and children; and call on the Environmental Protection Agency to officially classify Per- and Polyfluoroalkyl Substances and derivatives in all applications.

Your Reference Committee heard unanimous testimony in support of the spirit of Resolution 02. Testimony revealed that efforts to address PFAS contamination are underway in both Congress (Congressional PFAS Task Force formed in January 2019; Senate bill 3381, PFAS Accountability Act, introduced in March 2019) and the Administration (EPA PFAS Action Plan released in February 2019). Testimony further suggested that AMA advocacy efforts would be more effective if directed broadly at supporting these existing efforts, rather than in advocating for specific components of PFAS mitigation. We agree with this sentiment and offer substitute language drawn largely from that offered in testimony, and thus recommend that the substitute language be adopted in lieu of Resolution 02.

(16) RESOLUTION 03 – AMENDING H-490.913, SMOKE-FREE ENVIRONMENTS AND WORKPLACES, AND H-490.907, TOBACCO SMOKE EXPOSURE OF CHILDREN IN MULTI-UNIT HOUSING TO INCLUDE E-CIGARETTES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 03 be <u>amended by insertion and deletion</u> to read as follows:

RESOLVED, That our AMA amend policies H-490.913, Smoke-Free Environments and Workplaces, and H-490.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to include e-cigarettes and vaping by insertion and deletion as follows:

SMOKE-FREE <u>AND VAPE-FREE</u> ENVIRONMENTS AND WORKPLACES, H-490.913

On the issue of the health effects of environmental tobacco smoke (ETS) and passive smoke <u>and vape</u> exposure in the workplace and other public facilities, our AMA:
(1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in

defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating ~~smoke-free~~ ~~tobacco-free~~ smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, cigar, and e-cigarette smoking in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health

professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.

TOBACCO SMOKE AND VAPING EXPOSURE OF CHILDREN IN MULTI-UNIT HOUSING, H-490.907

Our AMA: (1) encourages federal, state and local housing authorities and governments to adopt policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting smoking and vaping in multi-unit housing; and (2) encourages state and local medical societies, chapters, and other health organizations to support and advocate for changes in existing state and local laws and policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting smoking and vaping in multi-unit housing.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 03 be adopted as amended.

Resolution 03 asks the AMA to amend and expand existing AMA policies H-490.913, Smoke-Free Environments and Workplaces and H-490.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to include e-cigarettes and vaping.

Testimony broadly supported the intent of Resolution 03, and specifically supported an amendment proffered by the New York delegation that would strengthen the resolution by inserting references to vaping in a few additional areas. Your Reference Committee supports these amendments and recommends a further technical amendment to clarify that vaping products are not tobacco products. While limited testimony suggested that vaping bans may be counterproductive to tobacco cessation goals, we believe that vaping bans would have a net positive effect on public health. For these reasons, we recommend that Resolution 03 be adopted as amended.

(17) RESOLUTION 04 – SUPPORT FOR THE USE OF PSYCHIATRIC ADVANCE DIRECTIVES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 04 be amended by deletion to read as follows:

RESOLVED, That our AMA ~~will~~ support efforts to increase awareness and appropriate utilization of psychiatric advance directives.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 04 be amended by deletion to read as follows:

~~RESOLVED, That our AMA will support the education of medical students and residents on psychiatric advance directives.~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 04 be adopted as amended.

Resolution 04 asks the AMA to support efforts to increase awareness and appropriate utilization of psychiatric advance directives and support the education of medical students and residents on psychiatric advance directives.

Your Reference Committee heard positive testimony on Resolution 04. We agree with the Massachusetts recommendation that the second resolve clause be deleted because (1) the intent appears to be encompassed by the first resolve clause, and (2) it seems to be a reaffirmation of AMA Policy H-85.956, Educating Physicians About Advance Care Planning, which broadly states the AMA's support for educating physicians about various aspects of advance directives. We also agree with a suggested minor syntax change to the first resolve clause. Accordingly, we recommend that Resolution 04 be adopted as amended.

(18) RESOLUTION 09 – ENDORSING THE CREATION OF A LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER (LGBTQ) RESEARCH IRB TRAINING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 09 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA work with appropriate stakeholders to support the creation of a model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-sexual, Transgender and Queer populations ~~research~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 09 be adopted as amended.

Resolution 09 asks the AMA to work with appropriate stakeholders to support the creation of a model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to Lesbian, Gay, Bisexual, Transgender and Queer research.

Your Reference Committee heard overwhelming testimony in support of this resolution. Testimony was also given that no other organization is addressing this issue. We offer a clarifying amendment and recommend that Resolution 09 be adopted as amended.

(19) RESOLUTION 10 – ENCOURAGING THE DEVELOPMENT OF MULTI-LANGUATE, CULTURALLY-INFORMED MOBILE HEALTH APPLICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 10 be amended by deletion to read as follows:

~~RESOLVED, That our AMA advocate for the revision of the National Standards on Culturally and Linguistically Appropriate Services of the U.S. Department of Health and Human Services to include medical applications and devices.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 10 be adopted as amended.

Resolution 10 asks the AMA to advocate for the revision of the National Standards on Culturally and Linguistically Appropriate Services of the U.S. Department of Health and Human Services to include mobile medical applications and devices and strengthen existing policy D-480.972, Guidelines for Mobile Medication Applications and Devices by including and employing linguistically appropriate and culturally informed content catered to underserved and low-income populations.

Your Reference Committee heard testimony in support of Resolution 10. The Massachusetts delegation brought up concern that the current guidelines listed on the Department of Health and Human Services website addressed “multimedia” but that it is not clear if this is inclusive enough of mobile health applications. Your Reference Committee discussed if there was a need to distinguish between mobile health applications and multimedia and whether that needed to be clarified. Ultimately, it was decided that it would not be strong policy to advocate for a wording change on the website, which in the future may be changed, resulting in irrelevant policy. Additionally, the Reference Committee agreed that the overarching message of the Department of Health and Human Services Guidelines was supportive of being more inclusive of cultural and language differences in healthcare. For these reasons, we recommend that Resolution 10 be adopted as amended.

(20) RESOLUTION 11 – REIMBURSEMENT FOR POST-EXPOSURE PROTOCOL FOR NEEDLESTICK INJURIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 11 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA encourages medical schools to ensure medical students can be reimbursed for the costs associated with post-exposure protocol for blood or body substance exposure ~~needlestick injuries~~ sustained during clinical rotations either by their insurance provider or the state's workers' compensation, where applicable; and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 11 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA encourages state societies to work with their respective workers' compensation program to include medical students as recipients of medical benefits in the event of ~~occupational injury or diseases~~ blood or body substance exposure sustained during clinical rotations.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 11 be adopted as amended.

Resolution 11 asks the AMA to encourage medical schools to ensure medical students can be reimbursed for costs associated with post-exposure protocol for needlestick injuries sustained during clinical rotation either by their insurance provider or the state's workers' compensation, where applicable and to encourage state societies to work with their respective workers' compensation program to include medical students as recipients of medical benefits in the event of needlestick injuries.

Testimony was heard in support of Resolution 11. Your Reference Committee believes that Resolution 11 could be strengthened by including blood and body substance exposure in addition to needlestick injuries, which can also be common during medical students' clinical rotations. We offer additional language to support this addition and recommend that Resolution 11 be adopted as amended.

(21) RESOLUTION 13 – ENGAGING STAKEHOLDERS FOR ESTABLISHMENT OF TWO-INTERVAL, OR PASS/FAIL, GRADING SYSTEM OF NON-CLINICAL CURRICULUM IN U.S. MEDICAL SCHOOLS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 13 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA policy H-295.866 be modified to read,

Supporting Two-Interval Grading Systems for Medical Education, H-295.866

Our AMA ~~acknowledges the benefits of~~ will work with stakeholders to encourage the establishment of a two-interval grading system ~~for the non-clinical curriculum and will work with stakeholders to strongly encourage it's establishment~~ in medical colleges and universities in the United States ~~for the non-clinical curriculum~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 13 be adopted as amended.

Resolution 13 asks the AMA to modify existing policy H-295.866 be modified to read: Our AMA supports a two-interval grading system for the non-clinical curriculum and will work with stakeholders to strongly encourage its establishment in medical colleges and universities in the United States.

Testimony was mostly supportive of Resolution 13 though there were also a few calls to refer this for study over the concern that more information is needed to explore the nuances of different pass/fail programs, how this may impact residency placement, and how this would vary and be enforced at medical schools across the country. However, Resolution 13 is amending current AMA policy that already recognizes the benefits of a two-interval grading system. Therefore your Reference Committee offers a clarifying amendment and supports that Resolution 13 be adopted as amended.

(22) RESOLUTION 18 –ADDRESSING HEALTH DISPARATIES THROUGH IMPROVED TRANSITION OF CARE FROM PEDIATRIC TO ADULT CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 18 be amended by deletion to read as follows:

~~RESOLVED, That our AMA MSS encourages research focused on transition of care in minority adolescents and young adults with chronic health condition or special medical needs to create culturally sensitive, effective transition of care initiatives and validate existing recommendations in these specific populations; and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 18 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA-MSS encourage the inclusion of pediatric to adult transition care training in the residency curricula ~~for specialties such as internal medicine, pediatrics, family medicine, and internal medicine pediatrics~~ with an emphasis on effective care for vulnerable patient populations such as ethnic and racial minorities.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 18 be adopted as amended.

Resolution 18 asks the AMA-MSS to encourage research focused on transition of care in minority adolescents and young adults with chronic health conditions or special medical needs to create culturally sensitive, effective transition of care initiatives and validate existing recommendations in these specific populations and also encourage the inclusion of transition care training in residency curricula with an emphasis on effective care for vulnerable patient populations such as ethnic and racial minorities.

Testimony on the VRC was universally in support of the spirit of this resolution. It was discussed in testimony that the AMA is not a research body and that the original phrasing of Resolution 18 was not clear on who would be conducting the proposed research. Additionally, as originally written, Resolution 18 presupposes that the research proposed would validate existing recommendations in pediatric to adult transition of care, when it's impossible to know that this will be the case without first conducting the research. Amendments were proposed by Massachusetts and the CEQM to strengthen the

resolution and testimony universally supported Resolution 18 with these amendments. For these reasons we recommend that Resolution 18 be adopted as amended.

(23) RESOLUTION 20 – ETHICAL USE OF CADAVERS IN MEDICAL EDUCATION AND RESEARCH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 20 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA ~~encourage~~ study ~~policies that prohibit~~ the use of unclaimed bodies ~~and work with the International Federation of Associations of Anatomists to uphold their guidelines for the use of cadavers~~ for ~~all~~ medical education and research purposes.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 20 be adopted as amended.

Resolution 20 asks the AMA to encourage policies that prohibit the use of unclaimed bodies and work with the International Federation of Associations of Anatomists to uphold their guidelines for the use of cadavers for all medical education and research purposes.

VRC testimony was mostly in support of Resolution 20. Compelling testimony was heard for all sides. Your Reference Committee recognizes that this is a sensitive issue and has taken that into consideration as this resolution was discussed. We offer amendments to strengthen this resolution and remove the reference to specific partner organizations. Ultimately, your Reference Committee believes that it would be best to have this resolution first referred for study to the Council on Ethical and Judicial Affairs (CEJA), which can be accomplished by asking the AMA to study the issue. We also recognize that there are many downstream effects that can be impacted by altering the rules surrounding the use of unclaimed bodies as cadavers in medical schools. Taking all of these points into consideration, we recommend that Resolution 20 be adopted as amended.

(24) RESOLUTION 23 – TRANSPARENCY IMPROVING INFORMED CONSENT FOR REPRODUCTIVE HEALTH SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 23 be amended by deletion to read as follows:

RESOLVED, That our AMA will work with relevant stakeholders ~~(American College of Obstetricians and~~

~~Gynecologists, American Academy of Family Physicians, and United Nations Population Fund (UNFPA))~~ to establish a list of Essential Reproductive Health Services~~, 10 including but not limited to:~~

- ~~Full contraception counseling including:~~
  - ~~Medication and device related contraceptives~~
  - ~~Prescription/provision of contraception including oral/topical medications~~
  - ~~Insertion and removal of IUDs, implanted devices~~
  - ~~Emergency contraception medication prescription in any circumstance~~
  - ~~Full spectrum sexual assault evaluation including STI testing and treatment and emergency contraception provision~~
  - ~~Miscarriage and ectopic pregnancy treatment~~
- ~~Postpartum and interval sterilization~~
- ~~Infertility treatments that include ovulation medications~~
- ~~Intrauterine insemination~~
- ~~In vitro fertilization~~
- ~~Ova and sperm retrieval and storage for future reproduction needs~~, and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 23 be amended by insertion to read as follows:

RESOLVED, That our AMA will advocate for legislation requiring healthcare organizations to clearly publish online and in points of service which Essential Reproductive Health Services are available at the organization along with any restrictions on Essential Reproductive Health Services at the institution, and include referral information to patients of other providers that cover the services within the same coverage area.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 23 be adopted as amended.

Resolution 23 asks the AMA to work with relevant stakeholders to establish a list of Essential Reproductive Health Services, and advocate for legislation requiring healthcare organizations to clearly publish online and in points of service which of these Essential

Reproductive Health Services are available at the organization along with any restrictions on any of these services at the institution.

Testimony heard for Resolution 23 was mixed, supporting adoption or reaffirmation. Two friendly amendments were offered by Wayne State University, including recommending that the list of Essential Reproductive Health Services listed in the first resolve clause be struck, and adding the inclusion of referral information to patients of other providers who offer these Essential Reproductive Health Services in the same coverage area. Your Reference Committee agreed that both of these recommendations help to strengthen Resolution 23. Including the list of Essential Reproductive Health Services was discussed, but it was ultimately decided that it could lead to arguments over what should be included in that list and could potentially hinder an otherwise strong policy moving forward. For these reasons we recommend that Resolution 23 be adopted as amended.

(25) RESOLUTION 24 – SUPPORT FOR VETERANS COURTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 24 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA supports the ~~establishment~~ use of Veterans Courts as a method of intervention for Veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 24 be adopted as amended.

Resolution 24 asks the AMA to support the establishment of Veterans Courts as a method of intervention for Veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.

Testimony was heard mostly in support of Resolution 24. The Committee on Legislation and Advocacy offered an amendment to existing policy H-100.955 in lieu of adopting Resolution 24, but your Reference Committee believes that this was not aligned with the original intent of the Resolution 24, which focuses on Veterans who may commit violent crimes, as opposed to the non-violent offenses discussed in H-100.955. The delegation from Massachusetts offered an amendment in recognition of the current existence of veterans courts, which was supported by the authors. We agree with this amendment and recommend that Resolution 24 be adopted as amended.

(26) RESOLUTION 26 – AMENDMENT TO H-150.949
HEALTHY FOOD OPTIONS IN HOSPITALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 26 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA encourage the availability of healthy, plant-based options at Medical Care Facilities by amending H-150.949, Healthy Food Options in Hospitals to read:

H-150.949 – HEALTHY FOOD OPTIONS IN ~~HOSPITALS~~ MEDICAL CARE FACILITIES

1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on ~~hospital~~ the premises of Medical Care Facilities.
2. Our AMA hereby calls on ~~US hospitals~~ all Medical Care Facilities ~~– including Hospitals, Skilled Nursing Facilities, Intermediate Care Facilities,~~ and Correctional Facilities ~~–~~ to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages.
3. Our AMA hereby calls for ~~hospital~~ Medical Care Facility cafeterias and inpatient meal menus to publish nutrition information.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 26 be adopted as amended.

Resolution 26 asks the AMA to expand existing policy H-150.949, Healthy Food Options in Hospitals to include all Medical Care Facilities and Correctional Facilities. The existing policy promotes healthy food in these settings to improve the health of patients, staff, and visitors by providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; and eliminating processed meats from menus; and providing and promoting healthy beverages. H-150.949 also calls for hospital cafeterias and inpatient meals to include nutritional information

Testimony on the VRC was supportive of Resolution 26 with amendments. The delegation from Massachusetts raised concern around the inclusion of Correctional Facilities in this resolution, stating that the AMA has separate policy on Correctional Facilities and they

should not be included in this resolution. Your Reference Committee believes that it is important to include Correctional Facilities on this list, since AMA-MSS supports healthy foods being offered to all prisoners, not just those who are actively receiving health care. Your Reference Committee also recommends removing the list of specific examples of Medical Care Facilities to be more succinct. For these reasons we believe that Resolution 26 should be adopted as amended.

(27) RESOLUTION 28 – SUNSCREEN DISPENSERS IN PUBLIC SPACES AS A PUBLIC HEALTH MEASURE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 28 be amended by deletion to read as follows:

RESOLVED, That our AMA support ~~the implementation of~~ free public sunscreen programs~~, including sunscreen dispensers and educational labels,~~ in public spaces, ~~such as parks, beaches, schools and other public places~~ where the population would have a high risk of sun exposure.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 28 be adopted as amended.

Resolution 28 asks the AMA to support the implementation of free public sunscreen programs, including sunscreen dispensers and educational labels, in public spaces such as parks, beaches, schools and other public places where the population would have a high risk of sun exposure.

Testimony heard was in support of the spirit of Resolution 28. Concerns were raised regarding the fiscal note and real-world application. The delegation from Massachusetts presented an amendment to change from “implementation” to “support” in order to lower the fiscal burden and increase the feasibility. Your Reference Committee agrees with this recommendation and offers an additional amendment to strike the examples of sunscreen programs and the examples of public spaces, in order to broaden the policy and allow for communities to tailor the program to their individual needs. With these amendments, we recommend adoption of Resolution 28.

(28) RESOLUTION 30 – ENSURING THE BEST IN-SCHOOL CARE FOR CHILDREN WITH SICKLE CELL DISEASE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 30 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA support the education of teachers and school officials on policies and protocols encouraging best practices for children with sickle cell disease, ~~in school accommodation to create an equitable educational environment for students with sickle cell disease through measures~~ such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school~~; and be it further~~, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 30 be amended by deletion to read as follows:

~~RESOLVED, That our AMA promote the education of teachers and school officials on policies and protocols encouraging best practices for children with sickle cell disease, such as accommodations, to ensure that they receive the best in school care, and are not discriminated against, based on current federal and state protections.~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 30 be adopted as amended.

Resolution 30 asks the AMA to support the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises, and supporting the education of teachers and schools officials on the protocols encouraging best practices for children with sickle cell disease, such as accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections.

Testimony supported Resolution 30 with amendments to combine resolve clauses and make the resolution more concise. Your Reference Committee chose to include the list of specific accommodations, as this will help educate schools and teachers on the accommodations they need to learn more about and implement. For these reasons your Reference Committee recommends that Resolution 30 be adopted as amended.

(29) RESOLUTION 31 – INCREASING ACCESS TO GANG-RELATED LASER TATTOO REMOVAL IN PRISON AND COMMUNITY SETTINGS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 31 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA ~~advocates for regulatory reforms, policies, and funding to increase access to gang-related laser tattoo removal in prison and community settings.~~ supports increased access to gang-related tattoo removal in prison and community settings.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 31 be adopted as amended.

Resolution 31 asks the AMA to advocate for regulatory reforms, policies, and funding to increase access to gang-related laser tattoo removal in prison and community settings.

Testimony supported Resolution 31 with the amendment to change "advocate" to "support." Your Reference Committee agrees with testimony that "advocate" would lead to a large fiscal burden, and "support" would be much more feasible and a better use of AMA advocacy resources. For these reasons your Reference Committee recommends that Resolution 31 be adopted as amended.

(30) RESOLUTION 36 – IMPROVING INCLUSIVENESS OF TRANSGENDER PATIENTS WITHIN ELECTRONIC MEDICAL RECORD SYSTEMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 36 be amended by deletion to read as follows:

RESOLVED, That our AMA amend policy H-315.967, Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation by insertion as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medicaid Documentation, H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, ~~and~~ preferred gender pronoun(s), preferred name, and an

inventory on current anatomy in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner ~~in order to guide screening, diagnostic, and treatment procedures based on the presence of appropriate organs rather than biological sex or gender identity~~; and (2) will advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 36 be adopted as amended.

Resolution 36 asks the AMA to amend policy H-315.967 by insertion to read:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, ~~and~~ preferred gender pronoun(s), preferred name, and an inventory of current anatomy in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner in order to guide screening, diagnostic, and treatment procedures based on the presence of appropriate organs rather than biological sex or gender identity; and (2) will advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

Testimony heard on Resolution 36 was mostly in support of the spirit of the resolution. While your Reference Committee acknowledges the argument that Resolution 36 could be a reaffirmation of AMA policy H-160.991, Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations, we believe that adding the specific language "…preferred name, and an inventory on current anatomy…" strengthens the resolution and makes it novel. The authors addressed these concerns previously with the MSS HOD Coordinating Committee. We offer an amendment from individual testimony on the VRC to remove the unnecessary justifying language "in order to guide screening, diagnostic, and treatment procedures based on the presence of appropriate organs rather than biological sex or gender identity," and recommend Resolution 36 be adopted as amended.

(31) RESOLUTION 37 – SUPPORT EXPANSION OF GOOD SAMARITAN LAWS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve of Resolution 37 be amended by deletion to read as follows:

~~RESOLVED, That our AMA advocate for the expansion of Good Samaritan Laws and development of 911 Medical Amnesty Laws nationally to ensure that any person who in good faith seeks medical assistance for a person experiencing a drug overdose him or herself shall not be arrested, charged, or prosecuted for a drug violation, including but not limited to: possession, parole violations, and drug induced homicide, if the evidence for the arrest, charge, or prosecution of such drug violation resulted solely from seeking such medical assistance; and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 37 be amended by deletion to read as follows:

RESOLVED, That our AMA amend policy D-95.977 by insertion as follows:

911 Good Samaritan Laws, D-95.977

Our AMA: (1) will support and endorse policies and legislation that provide protections ~~from prosecution for any drug related crime~~ for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; and (3) will work with the relevant organizations and state societies ~~to develop campaigns~~ to raise awareness about the existence and scope of Good Samaritan Laws.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 37 be adopted as amended.

Resolution 37 asks the AMA to advocate for the expansion of Good Samaritan Laws and development of 911 Medical Amnesty Laws nationally to ensure that any person who in good faith seeks medical assistance for a person experiencing or believed to be experiencing a drug overdose or who is experiencing a drug overdose him or herself

should not be arrested, charged, or prosecuted for a drug violation, including but not limited to: possession, parole violations, and drug-induced homicide, if the evidence for the arrest, charge or prosecution of such drug violation resulted solely from seeking medical assistance; and that AMA amend policy D-95.977 to read as follows: Our AMA: (1) will support and endorse policies and legislation that provide protections from prosecution for any drug-related crime for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; and (3) will work with the relevant organizations and state societies to develop campaigns to raise awareness about the existence and scope of Good Samaritan Laws.

Your Reference Committee heard mixed testimony on Resolution 37. There was an argument for reaffirmation of D-95.977, Good Samaritan Laws, by multiple delegations. Additionally, we point to the work already being done by the AMA in support of Good Samaritan Laws. In a letter to the National Council of Insurance Legislators, the AMA states the following:

> "The AMA has been very pleased to work closely with the nation's medical societies and harm reduction community to help support naloxone access laws in all 50 states as well as strong Good Samaritan protections."

The MSS HOD Coordinating Committee believes that the first resolve clause is a reaffirmation of existing policy, while the second resolve clause is novel. Your Reference Committee agrees, and offers an amendment to the second resolve clause to make the ask more feasible. We believe that raising awareness and education on Good Samaritan Laws is needed, but that leaving campaign development to the appropriate organizations at the state level who are familiar with the Good Samaritan Laws in their particular state is prudent. Your Reference Committee recommends that Resolution 37 be adopted as amended.

(32) RESOLUTION 42 – ADDRESSING THE RACIAL PAY GAP IN MEDICINE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 42 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA support ~~equal pay transparency measures, in which physicians (regardless of race) have appropriate means to access knowledge of a range of pay comparable to their white professional counterparts~~ efforts to increase the transparency and accountability of physician earnings through establishing transparency measures, in which physicians can access information including but not limited to the salaries and race of medical physicians.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 42 be amended by deletion to read as follows:

~~RESOLVED, That our AMA support equal pay transparency measures, in which physicians (regardless of race) have appropriate means to access knowledge of a range of pay comparable to their white professional counterparts.~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 42 be adopted as amended.

Resolution 42 asks the AMA to support measures of racial pay awareness and the specific challenges that minority physicians face in regards to equal pay financial attainment and that AMA support equal pay transparency measures, in which physicians (regardless of race) have appropriate means to access knowledge of a range of pay comparable to their white professional counterparts, and that AMA advocate for policy that mandates equal pay for physicians adjusted to hours works, years of practice, practice ownership status, board certification standards, IMG status, type of degree, demographics of practice and proportion of Medicare and Medicaid patients.

Your Reference Committee heard testimony that was strongly supportive of the resolution with amendments. Testimony addressed that the resolution language would be stronger and more actionable if the language addressed AMA support of the transparency and accountability measures so that physicians could access information more readily. For these reasons your Reference Committee recommends that Resolution 42 be adopted as amended.

(33) RESOLUTION 43 – REMOVING SEX DESIGNATION FROM THE PUBLIC PORTION OF THE BIRTH CERTIFICATE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 43 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA advocate for removal of “sex” as a ~~legal~~ designation on the public portion of the birth certificate and that it be visible for medical and statistical use only.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 43 be adopted as amended.

Resolution 43 asks the AMA to advocate for the removal of “sex” from the public portion of the birth certificate.

Testimony heard on Resolution 43 was mixed and amendments posted on the VRC were supported by the authors. Your Reference Committee believes there is no legal use for the sex designation in the public portion of the birth certificate, and specifying that the data be visible in the lower portion will likely be necessary for HOD buy-in. Your Reference Committee recognizes that this issue is multi-faceted and has impacts beyond just the birth certificate itself. If passed, this change would be significant and require many resources, but the advocacy and political capital needed would be worth it, as this is an important issue. For these reasons your Reference Committee recommends Resolution 43 be adopted as amended.

(34) RESOLUTION 48 – AFFIRMING THE RIGHT OF MINORS TO CONSENT TO VACCINATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first resolve clause of Resolution 48 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA-MSS support legislation that allows mature minors~~, who are able to understand the nature and consequences of their medical treatment,~~ to provide consent for routine immunizations as recommended by the Centers for Disease Control and Prevention. ~~(CDC)~~; ~~and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second resolve of Resolution 48 be amended by deletion to read as follows:

~~RESOLVED, That this policy immediately be forwarded to the AMA House of Delegates for consideration at Annual 2019~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 48 be adopted as amended.

Resolution 48 asks that AMA support legislation that allows mature minors, who are able to understand the nature and consequences of their medical treatment, to provide consent for routine immunizations as recommended by the Center for Disease Control (CDC) and that this policy be immediately forwarded to the AMA House of Delegates for consideration at Annual 2019.

Your Reference Committee heard testimony in support of the spirit of Resolution 48. The delegation from Massachusetts suggested removing the immediate forward clause, however, others supported keeping this clause due to legislation currently being considered by states and the urgent national scale of this issue. The delegation from Massachusetts also recommended removing the definition of mature minors in the first resolve clause, as it is redundant. Importantly, a similar resolution will be considered by the HOD at this Annual meeting (011-A-19, Mature Minor Consent to Vaccinations). Your Reference Committee believes that this is an important topic that needs to be discussed by the AMA, but that the best course of action would be to make this an internal MSS policy by removing the immediate forward clause and focus on supporting the existing resolution in the HOD at this Annual meeting.

(35) RESOLUTION 50 – REQUEST FOR BENZODIAZEPINE-SPECIFIC PRESCRIBING GUIDELINES FOR PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 50 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA ~~collaborate and urge the CDC and relevant stake holders to create~~ support the creation of national benzodiazepine-specific prescribing guidelines for physicians.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 50 be adopted as amended.

Resolution 50 asks the AMA to collaborate and urge the CDC and relevant stakeholders to create national benzodiazepine-specific prescribing guidelines for physicians.

Your Reference Committee heard testimony supporting Resolution 50 with amendments, however, authors were not in favor of the recommendations. Additional testimony addressed concerns with previous opioid prescribing guidelines. Testimony was heard that the original resolution advocating for the development of national prescribing guidelines would require a high fiscal note. It is also noted that Resolution 508-A-19 is being presented to the House of Delegates at the Annual meeting. Resolution 508-A-19 asks the AMA to raise the awareness of its members of the increased use of illicit sedative/opioid combinations leading to addiction and overdose death and that the AMA warn members and patients about this public health problem. The MSS could potentially

explore signing onto this policy in lieu of Resolution 50 (in the interest of not having duplicative policy). Your Reference Committee offers an amendment that will lower the fiscal burden. With this amendment, we recommend that Resolution 50 be adopted.

(36) RESOLUTION 51 – ENCOURAGE FEDERAL EFFORTS TO EXPAND ACCESS TO SCHEDULED DIALYSIS FOR UNDOCUMENTED PERSONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 51 be amended by insertion and deletion to read as follows:

RESOLVED, That our AMA ~~will encourage federal efforts to~~ support expand~~ed~~ access to scheduled dialysis for undocumented persons with end-stage renal disease.~~,~~ ~~possibly through additional funding of emergency Medicaid services.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 51 be adopted as amended.

Resolution 51 asks the AMA to encourage federal efforts to expand access to scheduled dialysis for undocumented persons with end-stage renal disease, possibly through additional funding of emergency Medicaid services.

Your Reference Committee heard mixed testimony, leaning in support of Resolution 51. Testimony focused on concerns of addressing Medicaid regulations at the state level for each state would be cumbersome. Amendments were offered to address concerns regarding the successful implementation of the resolution. We agree with these amendments and recommend that Resolution 51 be adopted as amended.

(37) COLA REPORT A - HOUSING MODIFICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in COLA Report A be amended by insertion and deletion to read as follows:

The AMA support legislation for health insurance coverage of housing modification benefits for

a. The elderly
b. Other populations, ~~that require this in order to mitigate preventable health conditions~~ including but not limited to the disabled, soon to be disabled, and other person(s) with physical and/or mental disability, that require these benefits in order to mitigate preventable health conditions.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in COLA Report A be adopted as amended and that the remainder of the report be filed.

At the 2018 MSS Interim meeting, MSS Resolution 08 asked the AMA to support legislation and other efforts to promote housing modifications as a means of falls prevention and improved disability access. The I-18 Reference Committee recommended that MSS Resolution 08 not be adopted and amended 1) to include a broader range of solutions, 2) the AMA and AMA-MSS is not an expert on housing modifications, and 3) this is covered in AMA policy by not by the AMA-MSS making it a candidate for internal adoption. The I-18 assembly found the amendments made by the reference committee were too broad and unactionable and referred this resolution for study by the Committee on Legislation and Advocacy who recommend that Resolution 08 be adopted and the remainder of the report filed.

There was no testimony on COLA Report A. We support the recommendation of this well-written report and offer one clarifying amendment.

(38) CGPH REPORT A - FOOD INSECURITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in CGPH Report A be amended by deletion to read as follows:

Your Committee on Global and Public Health recommends that the following recommendation is adopted and the remainder of this report is filed:

RESOLVED, That our AMA-MSS support evidence-based methods of addressing food insecurity. ~~including food prescription programs and medically tailored meals~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in CGPH Report A be adopted as amended.

At the Interim 2018 meeting, the AMA-MSS referred for study Resolution 51 titled "Utilizing Food Insecurity Screenings to Identify At-Risk Individuals" which asks the AMA-MSS to study the effectiveness of food prescriptions and hospital-based food assistance programs for those patients identified as food insecure. The Reference Committee referred this topic for study over concerns of feasibility, as it was noted that it is not within the purview of the AMA to dictate hospital practices, protocols, and partnerships. Additionally, the sources in the whereas clauses were not found to be adequate to support this without further study. CGPH recommends that Resolution 51 be adopted and the remainder of the report filed.

The limited testimony heard on CGPH Report A was in support of the recommendation. We believe that the phrase "…including food prescription programs and medically tailored meals" could limit the scope of the recommendation to just these two methods and recommend it be omitted. Additionally, the authors of the report note that food prescription programs are not yet evidence-based, as studies are currently in the stage of case reports. Your Reference Committee commends the authors on the thorough research done in this report and recommends that the report be adopted as amended.

(39) COLA REPORT C - DRIVING RESTRICTION LAWS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in COLA Report C be <u>amended by insertion and deletion</u> to read as follows:

Your Committee on Legislation and Advocacy recommends that the following recommendation be adopted and the remainder of this report filed:

~~1. That our AMA-MSS not adopt a formal position on standardization of state laws governing driving after Transient Loss of Consciousness.~~

1. That Resolution 06 A-18 not be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in COLA Report C be <u>adopted as amended</u>.

At the 2018 Annual meeting, Resolution 06 asked AMA-MSS to support evidence-based standardization of state driving restriction laws after transient loss of consciousness. While the importance of such a parameter is well-recognized, the AMA-MSS Assembly, after receiving mixed testimony, found that there was no current data to support developing a strong policy position. Therefore, the resolution was referred for study to the Committee on Legislation and Advocacy (COLA) to review research conducted on this topic, as policy adopting and implementation prior to research is premature. Accordingly, COLA produced this report, which details the various restrictions that exist across the country, the research conducted on how driving ability is actually impaired post-loss-of-consciousness and within certain timeframes, but, most importantly, how few controlled studies there are and

how recommendations vary by patient. COLA recommends that the following recommendation be adopted and the remainder of the report be filed: That AMA-MSS not adopt a formal position on standardization of state laws governing driving after Transient Loss of Consciousness.

Limited testimony on COLA Report C was in support of the spirit of the recommendation. However, as worded, the recommendation would create a policy that the AMA-MSS will not adopt any formal position on standardization of state laws governing driving after transient loss of consciousness – now or in the future. Your Reference Committee offers a clarifying amendment to make clear that the stance we are against taking is the one that was presented in the original resolution – Resolution 06 A-18. With this amendment, we recommend that the recommendations in COLA Report C be adopted as amended.

(40) RESOLUTION 46 – LAYING THE FIRST STEPS TOWARDS A TRANSITION TO A FINANCIAL AND CITIZENSHIP NEED-BLIND MODEL FOR ORGAN PROCUREMENT AND TRANSPLANTATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 46 be referred for report back at the 2019 Interim Meeting.

Resolution 46 asks that the AMA support and advocate for federal laws that remove financial barriers to transplant recipients such as provisions for expenses involved in the transplantation of organs incurred by the uninsured regardless of a legally defined United States Citizenship and Immigration Service (USCIS) status in the country as long as the person can show physical presence in the U.S. prior to needing the organ; and that the AMA promote and advocate for a 2020 national taskforce for organ procurement and transplant, and that the task force be renewed every 20 years to access the needs of the generation and account for change in demographics and technology; and asks the AMA to research a fiscal federal strategy to cover annual transplant costs in the U.S. for patients without insurance distributed among the over 200 transplant centers in the U.S.; and asks that AMA amend 6.2.1 in the Code of Ethics to explicitly state that organs should be allocated to recipients on the basis of ethically sound criteria without regard to a legally defined United States

Your Reference Committee heard extensive, mixed testimony, leaning against adoption of Resolution 46. Although testimony generally supported the spirit of the resolution, there was substantial concern about some aspects of the proposal, including the criteria for having established a “physical presence” in the United States, the feasibility of paying for such a proposal, and the fact that the AMA House of Delegates cannot directly amend AMA Ethical Opinions, among others. We recognize the importance of this topic and commend the authors for bringing it to the Section’s attention. However, we are not convinced that the outlined approach is the most appropriate one. We therefore recommend referral so that MSS may further study the issue and resume this important discussion at a future meeting.

(41) CME REPORT A - ACCESS FOR MEDICAL STUDENTS WITH DISABILITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that CME Report A be referred for report back at the 2019 Interim Meeting.

At the 2018 MSS Annual Meeting, Resolution 33 asked the AMA to support changes to Liaison Committee on Medical Education (LCME) and Commission on Osteopathic College Accreditation (COCA) accreditation standards to meet those of the Americans with Disabilities Act Amendments Act of 2008 and for the AMA to adopt technical standards as recommended in a publication by the American Association of Medical Colleges (AAMC). The AMA-MSS Assembly supported the spirit of the resolution by noted the concerns of the A-18 Reference Committee and referred the resolution for study to the Committee on Medical Education (CME). CME researched current policy and offer the following recommendations: Amending A-18 Resolution 33 first resolve to read: That AMA supports amending Liaison Committee on Medical Education (LCME) and the Commission on Osteopathic College Accreditation (COCA) accreditation requirements to urge all medical schools to make the process for appealing ADA determinations related to meeting technical standards for accommodations more transparent and easily accessible; Adopting A-18's Resolution 33 first resolve as amended; and that A-18's Resolution 33 second resolve not be adopted.

There was no testimony on CME Report A. While your Reference Committee felt that the report generally was well-reasoned and written, we note that the recommendations appear to omit action on some of the resolve clauses of the original resolution, even though the content of these resolves is discussed in the body of the report. We also note that the report is missing the standard recommendation for filing. For this reason, we recommend that Report A be referred for report back at a future meeting.

(42) COLA REPORT B - MANDATORY REPORTING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that COLA Report B be referred.

At the 2018 Interim meeting, Resolution 04 asked the AMA-MSS to support the requirement of all state medical boards to report sexual misconduct allegations by physicians to the appropriate law enforcement agencies. The I-18 Reference Committee recommended the resolution be referred to report due to: 1) unclear wording of the resolution that could allow for unintended consequence, 2) feasibility and scope. The Committee on Legislation and Advocacy (COLA) recommends that AMA advocate for universal mandatory reporting of sexual, physical, and emotional assault claims when the alleged perpetrator is any type of health care professional by convening a working group of AMA lawyers to develop a uniform and standard language that can be adopted by states using the precedent of model parity legislation and that the remainder of the report be filed.

Your Reference Committee heard testimony on COLA Report B only from the authors of the original resolution, who supported the report. While the report is well-intentioned, your Reference Committee is concerned that the current report goes beyond the scope of the original ask. By changing the resolution from internal to external, the language provided by the report bypasses important MSS policy review processes and the input from other students, Councilors, the federal advocacy team, and staff. Moreover, we are concerned about the ambiguity of some of the terms in the recommendation—for example, it is unclear to whom and from whom "universal reporting" would recur. For these reasons, we recommend that the report be referred for additional refinement.

(43) RESOLUTION 08 – INVESTIGATING ACANTHOSIS NIGRICANS FOR HIGH-RISK CHILDREN AND ADOLESCENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 08 not be adopted.

Resolution 08 asks that the AMA-MSS support research and evaluative studies to accurately determine the reliability and predictive effectiveness of acanthosis nigricans screening for children and adolescents at high risk of developing type 2 diabetes mellitus.

Your Reference Committee heard mostly supportive testimony on Resolution 08. We have carefully weighed the perspectives presented and found particularly compelling the testimony presented by the Massachusetts delegation, which argued that the sensitivity and specificity mentioned by the authors would lead to a substantial number of false positive screens, and that there is thus insufficient baseline evidence of acanthosis nigricans diagnosis as a risk factor for Type 2 DM in children and adolescents to justify the cost of further research. Several individuals also noted that this research is currently underway, questioning the impact of this resolution. While we respect the testimony presented by those in favor of this resolution and applaud their advocacy on behalf of patients, we do not believe that it would be appropriate to support further research given the current evidence and current research efforts. For these reasons, we recommend that Resolution 08 not be adopted.

(44) RESOLUTION 39 – SUPPORT OF VISUAL AIDS COVERED BY MEDICAID AND FURTHER RESEARCH IN PROPER EYE PRACTICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 39 not be adopted.

Resolution 39 asks the AMA to support policy that supports coverage of vision screenings and visual aids as well as support further research into the benefits of routine comprehensive eye exams.

Testimony was nearly in universal opposition to Resolution 39. The ask was very broad and essentially unactionable. Your Reference Committee would welcome more actionable policy on this topic presented in the future. For these reasons your Reference Committee recommends that Resolution 39 not be adopted.

(45) RESOLUTION 44 – PROMOTE ULTRASOUND AS A COST-EFFECTIVE MEASURE IN DIAGNOSTIC IMAGING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 44 not be adopted.

Resolution 44 asks that AMA amend policy H-480.950 by addition to read as follows: Our AMA affirms that ultrasound imaging is a safe, effective, and efficient tool when utilized by, or under the direction of, appropriately trained physicians and supports the educational efforts and widespread integration of ultrasound throughout the continuum of medical education. Our AMA promote use of ultrasound as a initial cost-effective diagnostic tool when applicable, particularly when cost is an inhibiting factor for patients.

Your Reference Committee heard testimony mostly in opposition to Resolution 44, stating that this addition does not add to or strengthen current policy. There was also debate that the new language could be detrimental to patients with low socioeconomic status (SES), who may opt for an ultrasound due to cost, when another diagnostic tool would be more appropriate. For these reasons we recommend that Resolution 44 not be adopted.

(46) RESOLUTION 47 – IMPROVING ACCESSIBILITY OF AMA-MSS RESOLUTIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 47 not be adopted.

Resolution 47 asks that AMA add AMA-MSS resolutions to a similar Policy Finder, to be updated semi-annually, for easy retrieval and review of past MSS actions.

Your Reference Committee heard mixed testimony, leaning against adoption of this resolution. Testimony addressed concern about the AMA maintaining separate databases to access policies. Testimony noted that the MSS Policy Digest is readily available and concerns regarding additional accessibility measures can be addressed through a Governing Council Action Item request. Additional testimony was heard indicating that some within the MSS explicitly preferred the current MSS Digest of Actions over a Policy Finder-like approach. It was specifically mentioned that using “ctrl+f” to search the Digest was easier than navigating the AMA Policy Finder. We therefore recommend that Resolution 47 not be adopted.

(47) RESOLUTION 49 – ENSURING FAIR PRICING OF DRUGS DEVELOPED WITH THE UNITED STATES GOVERNMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 49 not be adopted.

Resolution 49 asks the AMA to advocate for the Administration's proposed Medicare Part B rule change wherein Medicare Part B's target price for reimbursement of single source drugs is set at 126% of their average prices in sixteen countries (Austria, Belgium, Canada, Czech Republic, Finland, France, Germany, Greece, Ireland, Italy, Japan, Portugal, Slovakia, Spain and the United Kingdom) included in the Health and Human Services Assistant Secretary for Planning and Evaluation's analysis of drug price differences between those countries and Medicare Part B, provided that the rule change be updated to allow voluntary opting-out by physicians and/or vendors should either party determine the testing program is adversely affecting patient access, healthcare utilization, drug prices, or health outcomes; and that the AMA study: a) the consequences of Medicare Part B's new IRP-based reimbursement model with an emphasis on determining its effects on access to included pharmaceuticals, the cost of said pharmaceuticals, and overall health outcomes, b) the potential impacts on access to pharmaceuticals, their costs, and overall health outcomes were the current proposed policy expanded to multiple source drugs, and c) alternative IRP-based models that Medicare Part B could employ, including using a target price identified by IRP as a set point for negotiations between pharmaceutical companies and the government.

Testimony heard on the VRC for Resolution 49 was mixed. Testimony raised concerns about the public commentary proffered by the AMA recently that addressed the potential impact of the proposed transition over five years of the model to using target prices for Part B drugs that are heavily based on the international pricing index. Testimony also cautioned directing this policy towards a specific Administration, as this could change in the future and, as a result, policy may be weakened. Other concerns included the specificity of the resolution leading to inflexible policy if passed and the high fiscal note. Your Reference Committee supports the spirit of the resolution and would encourage the authors to propose a broader policy in the future, however, at this time we recommend that Resolution 49 not be adopted.

(48) RESOLUTION 52 – A RESOLUTION TO ENCOURAGE RECOVERY HOMES TO IMPLEMENT EVIDENCE-BASED POLICIES REGARDING ACCESS TO MEDICATION ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 52 not be adopted.

Resolution 52 asks the AMA to urge policy changes at recovery homes to allow patients to remain on Medication Assisted Treatment as prescribed by a provider, including buprenorphine/naloxone combinations, without restrictions or mandatory tapering of doses.

Your Reference Committee heard limited testimony on Resolution 52, all of which opposed the item as written. In particular, testimony raised concerns about the unintended consequences of allowing patients to remain on all forms of medication assisted treatment, including methadone, which carries with it serious abuse potential. We therefore recommend against adoption of Resolution 52, but we encourage the authors to consider reworking their proposal and submitting it for consideration at a future meeting.

(49) RESOLUTION 01 – INTEGRATION OF TEAM-BASED LEARNING IN U.S. MEDICAL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA-MSS policy 295.122MSS be reaffirmed in lieu of Resolution 01.

Resolution 01 asks the AMA-MSS to support the integration of team-based learning coursework/modules in medical school education, graduate medical education, and continuing medical education.

Your Reference Committee heard mixed testimony about Team Based Learning (TBL). Testimony focused on concern with mandating one form of learning over other forms of learning and the appropriateness of mandating such a requirement given institutional differences and preferences, as well as the ever-changing nature of medical education curricula. Testimony addressed that existing policy 295.122MSS addresses the spirit of the resolution by supporting evidence-based teaching methods, like TBL, and we believe that 295.122MSS should be reaffirmed in lieu of Resolution 01.

295.122MSS – MODERNIZATION OF MEDICAL EDUCATION ASSESSMENT AND MEDICAL SCHOOL ACCREDITATION

AMA-MSS will ask the AMA to: (1) vigorously work to establish medical education system reforms throughout the medical education continuum that demand evidence-based teaching methods that positively impact patient safety or quality of patient care; and (2) work with the Liaison Committee on Medical Education (LCME) to perform frequent and extensive educational outcomes assessment of specialized competencies in the medical school accreditation process at minimum every four years, requiring evidence showing the degree to which educational objectives impacting patient safety or quality of patient care are or are not being attained.

(50) RESOLUTION 06 – ADVOCATING FOR THE STANDARDIZATION AND REGULATION OF OUTPATIENT ADDICTION REHABILITATION FACILITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy D-95.968 be reaffirmed in lieu of Resolution 06.

Resolution 06 asks the AMA advocate for expansion of federal regulations of outpatient addiction rehabilitation centers in order to provide patient and community protection through evidence-based care and that the AMA encourage the enforcement of evidence-based care in outpatient addiction rehabilitation centers and the use of medication-assisted treatment where appropriate for the management of substance use disorders in outpatient addiction treatment facilities.

Testimony from the MSS HOD Coordinating Committee (HCC) suggested that Resolution 06 is a broad reaffirmation of AMA Policy D-95.968, Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder which, in part, directs the AMA to "advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities." The authors and others disagreed and offered an amendment by deletion of the second resolve clause, which they suggested would further differentiate the proposed policy from existing policy. We have carefully considered these perspectives and agree that Resolution 06 as drafted is indeed a reaffirmation of existing policy but that with some amendment it could be made novel. For this reason, at this time we recommend reaffirmation of existing policy in lieu of Resolution 06.

D-95.968 – SUPPORT THE ELIMINATION OF BARRIERS TO MEDICATION-ASSISTED TREATMENT FOR SUBSTANCE USE DISORDER

Our AMA will: (1) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (2) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.

(51) RESOLUTION 07 – SUPPORT FOR A NATIONAL SINGLE-PAYER HEALTH PROGRAM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA-MSS policies 165.007MSS, 165.009MSS, 165.011MSS, 165.012MSS, 165.017MSS, and 165.020MSS be reaffirmed in lieu of Resolution 07.

Resolution 07 asks the AMA to support the creation of a national single payer health system to expand access to care and reduce costs for patients, providers, and healthcare systems, and that AMA policies H-165.838-12 and H-165.844 be deleted, and H-165.888 be amended by striking clause B, which calls for the AMA to oppose any single payer systems which would result in an unfair concentration of market power and be detrimental to patients. Resolution 07 also asks the AMA to end its participation in the Partnership for America's Health Care Future and any other coalitions that exist to oppose a national single payer system.

Your Reference Committee heard mixed testimony on Resolution 07. Most testimony favored reaffirmation, citing extensive support within MSS policy for a single payer system, including:

- 165.007MSS: Steps in Advancing towards Affordable Universal Access to Health Insurance,
- 165.009MSS: Evaluation of the Principles of the Health Care Access Resolution,
- 165.011MSS: Medicaid Reform and Coverage for the Uninsured: Beyond Tax Credits,
- 165.012MSS: Covering the Uninsured as AMA's Top Priority,
- 165.017MSS: MSS Support for State-by-State Universal Health Care, and
- 165.020MSS: National Healthcare Finance Reform: Single Payer Solution.

Testimony also noted the existence of Council on Medical Service Report 8-A-19, Expanding AMA's Position on Healthcare Reform Options, which responds to a previous MSS-sponsored resolution on this topic and provides an avenue for MSS advocacy for a single payer system at the 2019 Annual Meeting of the AMA House of Delegates. While we appreciate the urgency-centered arguments presented by some, your Reference Committee agrees that neither additional MSS policy on this topic nor an additional item of business in the House of Delegates is warranted at this time, as policy on this topic will be considered at the 2019 Annual Meeting of the AMA House of Delegates. We therefore recommend reaffirmation of existing policy in lieu of Resolution 07.

165.007MSS: STEPS IN ADVANCING TOWARDS AFFORDABLE UNIVERSAL ACCESS TO HEALTH INSURANCE

(1) AMA-MSS recognizes the efforts of the American Medical Association (AMA) in assembling proposals for the advancement toward affordable universal access to health insurance and supports Expanding Health Insurance: The

AMA Proposal for Reform; (2) AMA-MSS recognizes the efforts of the American Academy of Family Physicians (AAFP) and the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in assembling proposals for advancing towards affordable universal access to health insurance and supports engaging in discussions with appropriate members to continue to refine existing policies; (3) AMA-MSS supports AMA policy D-165.974, Achieving Health Care Coverage for All: Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy.

165.009MSS: EVALUATION OF THE PRINCIPLES OF THE HEALTH CARE ACCESS RESOLUTION

(1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (2) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (5) AMA-MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (8)AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (9) AMA-MSS supports the inclusion of

reducing health care administrative cost and burden into any plan calling for affordable universal health care access.

165.011MSS: MEDICAID REFORM AND COVERAGE FOR THE UNINSURED: BEYOND TAX CREDITS

AMA-MSS will: (1) actively support the ongoing efforts of the AMA to reform Medicaid in order to increase access to health care among the uninsured and underinsured of our nation; (2) support the ongoing AMA efforts to implement graduated, refundable tax credits as a replacement for Medicaid; (3) make the active promotion and education of the AMA plan for health insurance reform a top priority; (4) work with the AMA to create and fund programming that will educate both physicians and patients about the AMA plan for insurance reform and publicize that plan to the general public.

165.012MSS: COVERING THE UNINSURED AS AMA'S TOP PRIORITY

AMA-MSS will ask the AMA to make the number one priority of the American Medical Association comprehensive health system reform that achieves reasonable health insurance for all Americans and that emphasizes prevention, quality, and safety while addressing the broken medical liability system, flaws in Medicare and Medicaid, and improving the physician practice environment.

165.017MSS: MSS SUPPORT FOR STATE-BY-STATE UNIVERSAL HEALTH CARE

AMA-MSS supports state-level legislation to implement innovative programs to achieve universal health care, including but not limited to single-payer health insurance

165.020MSS: NATIONAL HEALTHCARE FINANCE REFORM: SINGLE PAYER SOLUTION

(1) AMA-MSS supports the implementation of a national single payer system; and (2) while our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS.

(52) RESOLUTION 12 – ENCOURAGING MENTAL HEALTH FIRST AID IN THE COMMUNITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies H-345.972, H-345.984 and D-345.994 be reaffirmed in lieu of Resolution 12.

Resolution 12 asks that the AMA amend policy H-130.952 to encourage education in basic life support, first aid, mental health first aid and effective interventions for reducing, preventing, and treating mental health crises, injuries, and coronary heart disease, and asks the AMA to urge state and local medical societies to participate in the development and promotion of community programs for adults, children, businesses, community groups, and public servants to increase awareness of the potential benefits of training in basic life support and first aid to increase public knowledge, confidence, and motivation for responding to serious or potentially serious illness and injury situations and encourages physicians to discuss with their patients: (a) how to recognize and respond to emergency situations; and (b) proper utilization and activation of the local EMS and crisis intervention team (CIT) system; and (c) measures for reducing or eliminating potential risk factors for injuries and coronary heart disease; and (d) the availability and appropriateness of community programs in basic life support and first aid.

Testimony from the MSS HOD Coordinating Committee (HCC) suggested that Resolution 12 is a reaffirmation of several existing AMA policies including H-345.972, Mental Health Crisis Interventions; H-345.984, Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses; and D-345.994, Increasing Detection of Mental Illness and Encouraging Education. The utilization of a crisis intervention team (CIT) as mentioned in Resolution 12 is sufficiently covered by H- 345.972, Incorporating Mental Health First Aid, and the treatment of mental health crises are broadly covered by H-345.984 and D-345.994. VRC testimony was largely in agreement with reaffirmation. Your Reference Committee agrees with the HCC recommendation that Resolution 12 is a reaffirmation of existing policy.

H-345.972 – MENTAL HEALTH CRISIS INTERVENTION

Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities.

H-345.984 – AWARENESS, DIAGNOSIS AND TREATMENT OF DEPRESSION AND OTHER MENTAL ILLNESSES

1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.

3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

4. Our AMA recognizes the impact of violence and social determinants on women’s mental health.

D-345.994 INCREASING DETECTION OF MENTAL ILLNESS AND ENCOURAGING EDUCATION

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental

health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

(53) RESOLUTION 14 – INTEGRATING IMMIGRANT RIGHTS TRAINING INTO RESIDENCY EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy D-160.921 be reaffirmed in lieu of Resolution 14.

Resolution 14 asks the AMA to support immigration training pilot studies that aim to study feasibility, efficacy, and benefits of implements these programs within resident curriculum.

Your Reference Committee heard mixed testimony on Resolution 14, generally favoring reaffirmation. The MSS HOD Coordinating Committee (HCC) testified that the resolution is a reaffirmation of AMA Policy D-160.921, Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare, which in part directs the AMA to "work with appropriate stakeholders to educate medical providers [which would include residents] on the rights of undocumented patients while receiving medical care." HCC also pointed to existing AMA policy more broadly seeking to protect undocumented patients receiving medical care, including:

- H-350.957 Addressing Immigrant Health Disparities,
- D-440.927 Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services,
- D-65.992 Medical Needs of Unaccompanied, Undocumented Immigrant Children,
- H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients, and
- H-315.966 Patient and Physician Rights Regarding Immigration Status.

Some testimony supported the HCC conclusion; other testimony did not. While we fully recognize the importance of this issue, we do not believe that Resolution 14 as drafted is sufficiently different from AMA Policy D-160.921 to warrant new policy. We therefore recommend reaffirmation of existing policy.

D-160.921 – PRESENCE AND ENFORCEMENT ACTIONS OF IMMIGRATION AND CUSTOMS ENFORCEMENT (ICE) IN HEALTHCARE

Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.

(54) RESOLUTION 15 – EMERGENCY DEPARTMENT OBSERVATION UNITS (EDOUS): A STEP TOWARD REDUCING HEALTHCARE COSTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy H-130.940 be reaffirmed in lieu of Resolution 15.

Resolution 15 asks the AMA to support the broader implementation and continued advancement of Emergency Department Observation Units.

Testimony from the MSS HOD Coordinating Committee and others suggested that the ask of Resolution 15 is covered by existing AMA policy that more broadly addresses emergency department capacity—for example, AMA Policy H-130.940, Emergency Department Boarding and Crowding, which:

(1) congratulates the American College of Emergency Physicians for developing and promulgating solutions to the problem of emergency department boarding and crowding [note that ACEP has endorsed EDOUs as a “best practice” and has provided guiding principles for their development—see http://bit.ly/2HugehG];
(2) supports collaboration between organized medical staff and emergency department staff to reduce emergency department boarding and crowding;
(3) supports dissemination of best practices in reducing emergency department boarding and crowding...”

Testimony, including that from the resolution’s authors, supported amendments to make this policy internal to the MSS. We agree with and encourage this course of action, but recommend reaffirmation of Resolution 15 as currently written.

H-130.940 – EMERGENCY DEPARTMENT BOARDING AND CROWDING

Our AMA: 1. congratulates the American College of Emergency Physicians for developing and promulgating solutions to the problem of emergency department boarding and crowding; 2. supports collaboration between organized medical staff and emergency department staff to reduce emergency department boarding and crowding; 3. supports dissemination of best practices in reducing emergency department boarding and crowding; 4. continues to encourage entities engaged in measuring emergency department performance (e.g., payers, licensing bodies, health systems) to use evidence-based, clinical performance measures that enable clinical quality improvement and capture variation such as those developed by the profession through the Physician Consortium for Performance Improvement; 5. continues to support physician and hospital use and reporting of emergency medicine performance measures developed by the Physician Consortium for Performance Improvement; and 6. continues to support the harmonization of individual physician, team-based, and facility emergency medicine performance metrics so there is consistency in evaluation, methodology, and limited burden associated with measurement.

(55) RESOLUTION 19 – STRENGTHENING AMA-MSS COLLABORATIONS WITH ALLIED UNDERREPRESENTED MINORITY STUDENT ORGANIZATIONS AT THE LOCAL CHAPTER LEVEL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA-MSS policy 350.014MSS be reaffirmed in lieu of Resolution 19.

Resolution 19 asks the AMA-MSS to support local chapters to collaborate with allied medical student organizations to serve underrepresented minority medical students, including but not limited to Student National Medical Association, Latino Medical Student Association, and Asian Pacific American Medical Student Association, and to support regional leadership to provide local chapters with information on how to establish a Minority Liaison executive board position with constitutional duties aimed to address underrepresented minority student issues and to increase the membership of underrepresented minority students within AMA-MSS.

VRC testimony was supportive of the spirit of Resolution 19. Testimony from the MSS HOD Coordinating Committee (HCC) suggested that Resolution 19 is a broad reaffirmation of 350.014MSS, Youth Health Pipeline Programs Initiative, which states:

"AMA-MSS…(2) will collaborate with medical school AMA Sections to partner with, but not limited to, the Student National Medical Association, the Latino Medical Student Association, the Asian Pacific American Medical Student Association, and other concerned organizations to support the development of medical career exposure and hands-on educational internship programs for underrepresented in medicine (UIM) and disadvantaged students."

During discussion, your Reference Committee proposed that there is potential for the second resolve clause to be submitted as a Governing Council Action Item (GCAI). We agree that the creation of a Minority Liaison would be novel and an operational facet of the Medical Student Section that the Governing Council could act upon, noting that the overarching goal of this resolution – to encourage partnerships with minority medical associations – is already covered by existing AMA-MSS policy. For these reasons, we recommend that 350.014MSS be reaffirmed in lieu of Resolution 19.

350.014MSS – YOUTH HEALTH PIPELINE PROGRAMS INITIATIVE

AMA-MSS (1) supports the establishment of a Medical Education Outreach Subcommittee for Disadvantaged Students, i.e., defined socially, economically, and/or educationally, under the umbrella of the Minority Issues Committee and under mentorship of the Minority Affairs Section, with the mission of forming long-term partnerships with local medical societies to develop pipeline programs that increase underrepresented in medicine (UIM) medical student enrollment, as defined by the AAMC and (2) will collaborate with medical school AMA Sections to partner with, but not limited to, the Student National Medical Association, the Latino Medical Student Association, the Asian Pacific American Medical Student Association, and other concerned organizations to support the development of medical career exposure and hands-on educational internship programs for underrepresented in medicine (UIM) and disadvantaged students.

(56) RESOLUTION 21 – SUPPORTING A MINIMUM AGE LIMIT FOR TACKLE FOOTBALL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies H-470.959 and H-470.954 be reaffirmed in lieu of Resolution 21.

Resolution 21 asks the AMA to support the establishment of a minimum age limit in tackle football participants based on recommendations by the American Academy of Pediatrics and/or other appropriate stakeholders.

VRC testimony on Resolution 21 was mixed, leaning toward support. Testimony from the MSS HOD Coordinating Committee (HCC) suggested that Resolution 21 is a reaffirmation of existing AMA policies H-470.959, Reducing the Risk of Concussion and Other Injuries in Youth Sports, and H-470.954, Reduction of Sports-Related Injury and Concussion. While it could be argued that Resolution 21 is narrower than existing AMA policy, your Reference Committee believes that a broader umbrella policy on preventing head injuries in youth sports is more effective and therefore agrees with the HCC recommendation that H-470.959 and H-470.954 be reaffirmed in lieu of Resolution 21.

> H-470.959 REDUCING THE RISK OF CONCUSSION AND OTHER INJURIES IN YOUTH SPORTS
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> 1. Our American Medical Association promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion be removed immediately from the activity in which they are engaged and not return to competitive play, practice, or other sports-related activity without the written approval of a physician (MD or DO) or a designated member of the physician-led care team who has been properly trained in the evaluation and management of concussion. When evaluating individuals for return-to-play, physicians (MD or DO) or the designated member of the physician-led care team should be mindful of the potential for other occult injuries.
>
> 2. Our AMA encourages physicians to: (a) assess the developmental readiness and medical suitability of children and adolescents to participate in organized sports and assist in matching a child's physical, social, and cognitive maturity with appropriate sports activities; (b) counsel young patients and their parents or caregivers about the risks and potential consequences of sports-related injuries, including concussion and recurrent concussions; (c) assist in state and local efforts to evaluate, implement, and promote measures to prevent or reduce the consequences of concussions, repetitive head impacts, and other injuries in youth sports; and (d) support preseason testing to collect baseline data for each individual.
>
> 3. Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; (c) promote evidenced-based educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials,

school personnel, health professionals, and athletic trainers; and (d) encourage further research to determine the most effective educational tools for the prevention and management of pediatric/adolescent concussions.
4. Our AMA supports (a) requiring states to develop and revise as necessary, evidenced-based concussion information sheets that include the following information: (1) current best practices in the prevention of concussions, (2) the signs and symptoms of concussions, (3) the short-and long-term impact of mild, moderate, and severe head injuries, and (4) the procedures for allowing a student athlete to return to athletic activity; and (b) requiring parents/guardians and students to sign concussion information sheets on an annual basis as a condition of their participation in sports.

H-470.954 – REDUCTION OF SPORTS-RELATED INJURY AND CONCUSSION

1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.

2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.

3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.

4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective

biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.
5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from sub-concussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).

(57) RESOLUTION 22 – REDUCING UNNECESSARY POST-OPERATIVE LABS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies D-460.973 and H-480.940, and AMA-MSS policy 485.003MSS be reaffirmed in lieu of Resolution 22.

Resolution 22 asks the AMA to ask relevant stakeholders to develop an evidence-based algorithm to guide order to postoperative labs and urge ongoing evaluation and improvement of this algorithm based on outcomes data and that the AMA promote the education of healthcare providers regarding costs of lab services, populations at low-risk for postoperative complications, and potential negative consequences for repetitive lab procedures in the inpatient setting.

Testimony from the MSS HOD Coordinating Committee (HCC) suggested that Resolution 22 is a reaffirmation of AMA policy D-460.973 and H-480.940 and AMA-MSS policy 485.003MSS. Additional testimony heard on Resolution 22 nearly universally agrees that existing AMA policy addressed the issues of cost-effectiveness and guidelines for post-operative labs, and that this resolution does not present a novel topic. Testimony from the author calls for a distinction to made between “guidelines” and “algorithm.” Importantly, your Reference Committee believes that H-480.940 addresses this distinction with broad policy, as it aims to use “augmented intelligence…to improve patient outcomes.” Your Reference Committee would also recommend the author reach out to the appropriate AMA council for their opinion and potential further action, specifically regarding the request for an algorithm to be created. For these reasons, your Reference Committee recommends that existing policies D-460.973, H-480.940 and 485.003MSS be reaffirmed in lieu of Resolution 22.

D-460.973 – COMPARATIVE EFFECTIVENESS RESEARCH

Our AMA will solicit from our members and others articles or postings about current clinical topics where comparative effectiveness research should be conducted and will periodically invite AMA members to recommend topics where the need for comparative effectiveness research is most pressing, and the results will be forwarded to the

Patient-Centered Outcomes Research Institute (PCORI) once it is established, or to another relevant federal agency.

H-480.940 – AUGMENTED INTELLIGENCE IN HEALTH CARE

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:
1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that: a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team; b. is transparent; c. conforms to leading standards for reproducibility; d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

485.003MSS – MACHINE INTELLIGENCE IN HEALTHCARE

That our AMA-MSS supports the use of machine intelligence as a complementary tool in making clinical decisions; (2) That our AMA-MSS supports ethical, rapid development and deployment of machine intelligence research and machine learning techniques to improve clinical decision-making, including diagnosis, patient care,

and health systems management;(3) That our AMA-MSS supports partnerships with organizations actively developing machine intelligence and other appropriate groups to evaluate clinical outcomes, develop regulatory guidelines for the use of machine intelligence in healthcare, and ensure further developments will be beneficial to patients, physicians, and society; (4) That our AMA-MSS encourages the education of medical students and physicians on the use of machine intelligence in healthcare; (5) That our AMA-MSS supports increased utilization of the term "machine intelligence" rather than the term “artificial intelligence” when considering the use of computers to parse data, learn from it, and develop clinical guidelines or facilitate clinical decision-making.

(58) RESOLUTION 25 – ADVOCATE FOR A GLOBAL CARBON PRICING SYSTEM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy H-135.977 be reaffirmed in lieu of Resolution 25.

Resolution 25 asks the AMA to amend H-135.977 to include a clause that calls for the AMA to advocate for a global carbon pricing system to abate climate change, in addition to the current asks to endorse the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting; to urge Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production; to endorse increased recognition of the importance of nuclear energy’s role in the production of electricity; and encourage research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and encourage humanitarian measures to limit the burgeoning increase in world population.

Your Reference Committee heard mixed testimony on Resolution 25, either supporting adoption or reaffirmation. The MSS HOD Coordinating Committee (HCC) and others testified that the resolution is a reaffirmation of AMA Policy H-135.977, Global Climate Change - The "Greenhouse Effect," which in part: “urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production” and “encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels.” The authors and others argued that because the proposed policy is more specific than the existing policy, it should not be considered a reaffirmation. We respectfully disagree, noting that the ask of Resolution 25 is encompassed by H-135.977 (i.e., a carbon pricing system could be part of the “comprehensive, integrated natural resource and energy utilization policy” called for in existing policy). We note further that the AMA has neither the expertise nor the influence in this area to dictate to policymakers the best method for curtailing climate change. For these reasons, we recommend that existing policy be reaffirmed in lieu of Resolution 25.

H-135.977 GLOBAL CLIMATE CHANGE – THE "GREENHOUSE EFFECT"

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting; (2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production; (3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity; (4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and (5) encourages humanitarian measures to limit the burgeoning increase in world population.

(59) RESOLUTION 27 – LIVER TRANSPLANT GUIDLEINES REGARDING PATIENTS WITH HISTORY OF PSYCHIATRIC DISORDERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies H -370.982 and H-345.983 be reaffirmed in lieu of Resolution 27.

Resolution 27 asks the AMA support sound guidelines for national transplant eligibility policies and support the appropriate utilization of neuropsychiatric disorders to assess the eligibility of all patients for liver transplantation.

While testimony generally supported the intent of Resolution 27, the MSS HOD Coordinating Committee noted that it could be viewed as a reaffirmation of AMA Policy H-370.982, Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients, which broadly addresses eligibility and prioritization criteria for organ transplant, and AMA Policy H-345.983, Medical, Surgical, and Psychiatric Service Integration and Reimbursement, which supports "standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients."

Testimony supported the assertion that the first resolve clause is addressed by existing policy, but there was disagreement about the novelty of the second resolve clause. Testimony also suggested that the resolution as written might be so vague as to be unactionable. A variety of amendments were offered to address these concerns. Your Reference Committee carefully considered these amendments, but we do not believe that they sufficiently address the issues of novelty or actionability. We therefore recommend reaffirmation of existing policy in lieu of Resolution 27.

H-370.982 – ETHICAL CONSIDERATIONS IN THE ALLOCATION OF ORGANS AND OTHER SCARCE MEDICAL RESOURCES AMONG PATIENTS

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula. (3) Decision-making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions. (4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the

reasoning behind the decision. (5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession. (6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them. (7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.

H-345.983 MEDICAL, SURGICAL, AND PSYCHIATRIC SERVICE INTEGRATION AND REIMBURSEMENT

Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients.

(60) RESOLUTION 29 – ACCURATE COLLECTION OF PREFERRED LANGUAGE AND DISAGGREGATED RACE & ETHNICITY TO CHARACTERIZE HEALTH DISPARITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policy D-478.995 be reaffirmed in lieu of Resolution 29.

Resolution 29 asks the AMA to amend policy H-315.996 by inserting “preferred language” to the list of information to be obtained from the patient; and asks the AMA to amend policy H-350.954 to encourage the disaggregation of demographic data regarding racial and ethnic groups, including but not limited to American Indian/Alaska Native (AIAN); Asian, Native Hawaiian, and Pacific Islander (AANHPI); Latinx; Hispanic White; non-Hispanic White; and Black/African American populations in order to reveal the disparities in health outcomes and representation in medicine that exist within the current classifications of racial and ethnic groups; and asks the AMA to encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race and ethnicity.

Your Reference Committee heard mostly supportive testimony on Resolution 29. Testimony from the MSS HOD Coordinating Committee (HCC) suggested that Resolution 29 is a reaffirmation of existing AMA policy D-478.995, National Health Information Technology, however, the Committee on Legislation and Advocacy and the Minority

Affairs Section, as well as several state delegations, support Resolution 29 as written. While your Reference Committee is sympathetic to the author's arguments and believes the first resolve clause could be supported as novel policy, we agree with HCC that the second and third resolve clauses are similar to existing policy. We therefore recommend that AMA policy D-478.995 be reaffirmed in lieu of Resolution 29.

> D-478.995 – NATIONAL HEALTH INFORMATION TECHNOLOGY
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> 1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care
> 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
> 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
> 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

(61) RESOLUTION 32 – INCREASED COVERAGE FOR HPV VACCINATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies H-440.872 and D-440.955 be reaffirmed in lieu of Resolution 32.

Resolution 32 asks the AMA to advocate for the addition of Medicaid coverage for GARDASIL ® 9 (Human Papillomavirus 9-valent Vaccine, Recombinant) or equivalent Human Papillomavirus 9-valent Vaccine for male and female patients between the ages of 18 and 26.

Testimony, including that from the MSS HOD Coordinating Committee, unanimously supported reaffirmation of existing policy in lieu of Resolution 32:

- H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, which "recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination" and "supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures…"
- D-440.955, Insurance Coverage for HPV Vaccine, which "encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients…"

Additionally, concerns from delegations included the restrictive ages noted in the resolve clause and the high fiscal note. We agree and recommend reaffirmation.

H-440.872 HPV VACCINE AND CERVICAL CANCER PREVENTION WORLDWIDE

(1) Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.
(2) Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
(3) Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

D-440.995 INSURANCE COVERAGE FOR HPV VACCINE

Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices; (2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.

(62) RESOLUTION 33 – CURTAILING GREENHOUSE GAS EMISSIONS TO NET ZERO IN THE HEALTH SECTOR

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies H-135.923, H-135.938 and H-135.939 be reaffirmed in lieu of Resolution 33.

Resolution 33 asks that the AMA advocate for the US healthcare system, including but not limited to hospitals, clinics and ambulatory care centers to decrease carbon emissions to half of 2010 levels by 2030 and reach net zero carbon emissions by 2050, so as to commit

to decreasing the healthcare sector's contribution to an increase in temperature beyond 1.5°C over the next century, and that the AMA urgently advocate for state and national programs that enable parties within the healthcare system to quantify their energy consumption and carbon emissions as well as identify avenues to improve energy efficiency and decrease net carbon emissions.

Your Reference Committee heard testimony that was mostly supportive of the spirit of Resolution 33, though with significant concerns. Concern was noted around the specificity of the targets presented in the resolve clauses. Testimony also questioned if this ask was within the scope of the AMA to achieve. Your Reference Committee agrees with the testimony heard and believes that a broader policy would be more effective. While amendments were offered to address these concerns, we find that the spirit of this resolution is captured in existing policies H-135.923, AMA Advocacy for Environmental Sustainability and Climate; H-135.938, Global Climate Change and Human Health; and H-135.939, Green Initiatives and the Health Care Community. For these reasons we recommend that these policies be reaffirmed in lieu of Resolution 33.

> H-135.923 – AMA ADVOCACY FOR ENVIRONMENTAL SUSTAINABILITY AND CLIMATE
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> Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
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> H-135.938 – GLOBAL CLIMATE CHANGE AND HUMAN HEALTH
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> Our AMA: 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor. 2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies. 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public;

and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

H-135.939 – GREEN INITIATIVES AND THE HEALTH CARE COMMUNITY

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

(63) RESOLUTION 35 – IMPLEMENTING A STANDARDIZED PATIENT FLAG SYSTEM IN THE ELECTRONIC MEDICAL RECORD

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies H-215.978 and H-515.966 be reaffirmed in lieu of Resolution 35.

Resolution 35 asks the AMA to encourage all healthcare facilities to implement a standardized patient flag system in electronic medical records in order to reduce workplace violence.

Testimony from the MSS HOD House Coordinating Committee (HCC) suggested that Resolution 35 is a reaffirmation of AMA Policy 515.966, Violence and Abuse Prevention in the Health Care Workplace. Your Reference Committee heard mixed testimony on Resolution 35. Testimony generally supported the spirit of this resolution and the intent to

protect healthcare workers from potentially violent patients, but there was concern that flagging patients could adversely affect the care they receive as a result of provider bias. It also was unclear whether encouragement to implement standardized patient flag systems should be directed at facilities or at EHR vendors.

Our analysis of existing AMA policy found that this topic is addressed broadly via support for stakeholder organizations with expertise in this area—in particular, AMA Policy H-215.978, Workplace Violence Prevention, which:

(1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and The Joint Commission to develop guidelines or standards regarding hospital security issues and recognizes these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians are advised [note: The Joint Commission has created a "Workplace Violence Prevention Resources for Health Care portal" to share resources for preventing workplace violence in healthcare settings, including basic criteria for flagging patients—see https://www.jointcommission.org/workplace_violence.aspx; and

(2) encourages physicians to: work with their hospital safety committees to address the security issues within particular hospitals; become aware of and familiar with their own institution's policies and procedures; participate in training to prevent and respond to workplace violence threats; report all incidents of workplace violence; and promote a culture of safety within their workplace.

We further note that AMA Policy H-515.966, Violence and Abuse Prevention in the Health Care Workplace, "encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; develop policies to assess and manage reported occurrences of workplace violence and abuse; make training courses on workplace violence prevention available to employees and consultants; and include physicians in safety and health committees."
Given the uncertainty surrounding the propriety of the proposed policy, the extensive body of AMA policy on violence in the healthcare workplace, and the ongoing work of expert stakeholder organizations, we recommend reaffirmation of existing policy in lieu of Resolution 35.

H-215.978 – WORKPLACE VIOLENCE PREVENTION

Our AMA: (1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and The Joint Commission to develop guidelines or standards regarding hospital security issues and recognizes these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians are advised; and (2) encourages physicians to: work with their hospital safety committees to address the security issues within particular hospitals; become aware of and familiar with their own institution's policies and procedures; participate in training to prevent and respond to workplace

violence threats; report all incidents of workplace violence; and promote a culture of safety within their workplace.

H-515.966 VIOLENCE AND ABUSE PREVENTION IN THE HEALTH CARE WORKPLACE

Our AMA encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; develop policies to assess and manage reported occurrences of workplace violence and abuse; make training courses on workplace violence prevention available to employees and consultants; and include physicians in safety and health committees.

(64) RESOLUTION 40 – TRANSGENDER AND INTERSEX CARE TRAINING FOR SCHOOL HEALTH PROFESSIONALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies H-160.991 and H-295.878 and AMA-MSS policy 65.017MSS be reaffirmed in lieu of Resolution 40.

Resolution 40 asks the AMA to recommend school-based health professionals serving children and adolescents receive training in the physical and mental development of youth with gender dysphoria and/or difference in sex development, and that this training be periodically assess and renewed.

Your Reference Committee heard limited, but mixed, testimony on Resolution 40. While all testimony supported the spirit of Resolution 40, testimony from the MSS HOD Coordinating Committee and others noted general overlap between the proposed policy and 65.017MSS, Lesbian, Gay, Bisexual, and Transgendered Patient-Specific Training Programs for Healthcare Providers, which asks the AMA to “support the training of healthcare providers in cultural competency as well as in physical health needs for lesbian, gay, bisexual, and transgender patient populations.” We appreciate the fact that 65.017MSS is internal policy while Resolution 40 would be external policy (i.e., transmitted for consideration by the House of Delegates (HOD)). We note, however, that when the MSS transmitted the resolution that generated 65.017MSS to the HOD less than three years ago, it was deemed to be a reaffirmation of AMA policies H-160.991, Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations, and H-295.878, Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education. We therefore believe it is reasonable to surmise that if Resolution 40 were transmitted to the HOD, it too would be deemed a reaffirmation of existing policy, and we therefore recommend reaffirmation of existing policy.

H-160.991 – HEALTH CARE NEEDS OF LESBIAN, GAY BISEXUAL, TRANGENDER AND QUEER POPULATIONS

(1) Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.(2) Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.(3) Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.(4) Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the

provision of high quality and culturally competent care to LGBTQ people.

H-295.878 – ELIMINATING HEALTH DISPARITIES – PROMOTING AWARENESS AND EDUCATION OF LESBIAN, GAY, BISEXUAL, TRANSGENDER AND QUEER (LGBTQ) HEALTH ISSUES IN MEDICAL EDUCATION

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBTQ health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBTQ patients.

65.017MSS – LESBIAN, GAY, BISEXUAL, AND TRANSGENDERED PATIENT SPECIFIC TRAINING PROGRAMS FOR HEALTHCARE PROVIDERS

AMA-MSS will ask the AMA to support the training of healthcare providers in cultural competency as well as in physical health needs for lesbian, gay, bisexual, and transgender patient populations

(65) RESOLUTION 41 – ENHANCE PROTECTIONS FOR PATIENTS SEEKING HELP FOR PEDOPHILIC URGES AND THE PHYSICIANS TREATING THEM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies H-345.981 and H-373.995 be reaffirmed in lieu of Resolution 41.

Resolution 41 asks that AMA support the development of clear reporting guidelines for physicians confidentially treating patients with pedophilic desires who have not acted on these urges and that AMA advocate for increased training and awareness for physicians

about the incidence of these pedophilic desires in the general population and potential preventive treatment options, and that AMA support confidential preventive treatment of people with pedophilic desires who have not acted on these urges.

Your Reference Committee heard divided testimony on Resolution 41. While we recognize the importance of this issue, we heard compelling testimony suggesting that the ask of the resolution is broadly covered by existing AMA policy opposing government interference in patient counseling (H-373.995) and reducing the stigma of mental illness (H-345.981). Testimony also revealed that a similar resolution was considered at the 2018 MSS Interim Meeting and was deemed to be a reaffirmation of current policy. Without substantial differences from that I-18 policy, we recommend reaffirmation.

H-345.981 – ACCESS TO MENTAL HEALTH SERVICES

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment.

H-373.995 – GOVERNMENT INTERFERENCE IN PATIENT COUNSELING

(1) Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients. (2) Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients. (3) Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine. (4) Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit

to the patient, a substantial public health justification, or both. (5) Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter: A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care? B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives? C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies? D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care? E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships? F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes? G. Is there a process for appeal to accommodate individual patients' circumstances? (6) Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

(66) RESOLUTION 45 – INVESTIGATION OF EXISTING APPLICATION BARRIERS FOR OSTEOPATHIC MEDICAL STUDENTS APPLYING FOR AWAY ROTATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA policies H-295.876 and H-295.867 be reaffirmed in lieu of Resolution 45.

Resolution 45 asks that AMA investigate application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations.

Mixed testimony was heard on Resolution 45. The Committee on Medical Education (CME) remained neutral, but did point out that similar policy does already exist and that Resolution 45 is unlikely to yield a change. The MSS HOD Coordination Committee (HCC) provided testimony noting that the AMA does not have the capability to conduct an investigation into this topic. Your Reference Committee agrees with the testimony heard. The spirit of this resolution is covered by existing policy and the ultimate goal may be better achieved through a Governing Council Action Item (GCAI) request. We therefore recommend that AMA policies H-295.876, Equal Fees for Osteopathic and Allopathic Medical Students, and H-295.867, Expanding the Visiting Student Application Service for Visiting Student Electives in the Fourth Year, be reaffirmed in lieu of Resolution 45.

H-295.876 – EQUAL FEES FOR OSTEOPATHIC AND ALLOPATHIC MEDICAL STUDENTS

1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training. 2. Our AMA encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.

H-295.867 – EXPANDING THE VISITING STUDENTS APPLICATION SERVICE FOR VISITING STUDENT ELECTIVES IN THE FOURTH YEAR

1. Our American Medical Association strongly encourages the Association of American Medical Colleges (AAMC) to expand eligibility for the Visiting Students Application Service (VSAS) to medical students from Commission on Osteopathic College Accreditation (COCA)-accredited medical schools.
2. Our AMA supports and encourages the AAMC in its efforts to increase the number of members and non-member programs in the VSAS, such as medical schools accredited

by COCA and teaching institutions not affiliated with a medical school.

3. Our AMA encourages the AAMC to ensure that member institutions that previously accepted both allopathic and osteopathic applications for fourth year clerkships prior to VSAS implementation continue to have a mechanism for accepting such applications of osteopathic medical students.