

Reference Committee B

BOT Report(s)

- 07 Council on Legislation Sunset Review of 2011 House Policies
- 14 Pharmaceutical Advertising in Electronic Health Record Systems
- 18* Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19

Resolution(s)

- 201 Ensuring Continued Enhanced Access to Healthcare via Telemedicine and Telephonic Communication
- 202 Prohibit Ghost Guns
- 203 Ban the Gay/Trans (LGBTQ+) Panic Defense
- 204 Insurers and Vertical Integration
- 205 Protection of Peer-Review Process
- 206* Redefining the Definition of Harm
- 207* Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education
- 208* Increasing Residency Positions for Primary Care
- 209* Making State Health Care Cost Containment Council Datasets Free of Cost and Readily Available for Academic Research
- 210* Ransomware and Electronic Health Records
- 211* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-Dose Medications for Multiple Patients
- 212* ONC's Information Blocking Regulations
- 213* CMMI Payment Reform Models
- 214* Status of Immigration Laws, Rules, and Legislation During National Crises and Addressing Immigrant Health Disparities
- 215* Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs
- 216* Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies
- 217* Amending H-150.962, Quality of School Lunch Program to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs During COVID-19
- 218* Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity
- 219* Oppose Tracking of People who Purchase Naloxone
- 220* Equal Access to Adoption for the LGBTQ Community
- 221* Support for Mental Health Courts
- 222* Advocating for the Amendment of Chronic Nuisance Ordinances
- 223* Supporting Collection of Data on Medical Repatriation
- 224* Using X-Ray and Dental Records for Assessing Immigrant Age

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-JUN-21

Subject: Council on Legislation Sunset Review of 2011 House Policies

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee B

- 1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for
4 review and specifying the procedures to follow:
5
- 6 1. As the House of Delegates (House) adopts policies, a maximum ten-year time horizon shall
7 exist. A policy will typically sunset after ten years unless action is taken by the House to retain
8 it. Any action of our AMA House that reaffirms or amends an existing policy position shall
9 reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
10
 - 11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
13 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall
14 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
15 asked to review policies shall develop and submit a report to the House identifying policies that
16 are scheduled to sunset; (d) For each policy under review, the reviewing council can
17 recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain
18 part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each
19 recommendation that it makes to retain a policy in any fashion, the reviewing council shall
20 provide a succinct, but cogent justification (f) The Speakers shall determine the best way for
21 the House to handle the sunset reports.
22
 - 23 3. Nothing in this policy shall prohibit a report to the House or resolution to sunset a policy
24 earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more
25 current policy, or has been accomplished.
26
 - 27 4. The AMA councils and the House should conform to the following guidelines for sunset: (a)
28 when a policy is no longer relevant or necessary; (b) when a policy or directive has been
29 accomplished; or (c) when the policy or directive is part of an established AMA practice that is
30 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House
31 of Delegates Reference Manual: Procedures, Policies and Practices.
32
 - 33 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
34
 - 35 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

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

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-100.972	Generic vs Brand Medications	Our AMA will advocate to the US Food and Drug Administration against removal of generic medications from the market in favor of more expensive brand name products based solely on a lack of studies of the efficacy of the generic drug. Citation: Res. 220, I-11;	Retain – this policy remains relevant.
D-100.973	Stricter Oversight of Homeopathic Products by the Food and Drug Administration	Our AMA will urge the US Food and Drug Administration to review the existing regulatory framework for the approval and marketing of homeopathic drug products, including the Compliance Policy Guide, to determine if the current system is sufficient to reasonably ensure the safety and effectiveness of such products. Citation: (BOT action in response to referred for decision Res. 521, A-10; Reaffirmation A-11)	Rescind. FDA issued new draft guidance on Homeopathic products in 2019.
D-130.989	Coverage of Emergency Services	Our AMA: (1) will promote legislation, regulation, or both to require all health payers to utilize the AMA’s definition of “emergency medical condition;” (2) will promote legislation, regulation, or both to require all health payers, including ERISA plans and Medicaid fee-for-service, to cover emergency services according to AMA policy; and (3) in conjunction with interested national medical specialty societies, continue to work expeditiously toward a comprehensive legislative solution to the continued expansion of EMTALA and problems under its current rules. Citation: (Res. 229, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
D-160.993	Limitation of Scope of Practice of Certified Registered Nurse Anesthetists	Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA’s policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals.	Retain – this policy remains relevant.

		Citation: (Res. 220, I-01; Reaffirmed: CMS Rep. 7, A-11)	
D-190.978	HIPAA Privacy Regulations	<p>The AMA will:</p> <ol style="list-style-type: none"> 1. Not support repeal of the final privacy rule under the Congressional Review Act because the time for Congress to act under that Act has passed. 2. Continue its current strong advocacy efforts to improve and strengthen the final privacy rule while decreasing the administrative burdens it places upon physicians and other health care providers. 3. Partner actively with other relevant groups, such as state and national specialty medical societies, to look for other options for improvement and change and forward these to Department of Health and Human Services Secretary Thompson. 4. Communicate frequently with all interested parties about the progress of this process. <p>Citation: (BOT Action in response to referred for decision Res. 240, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Rescind. This policy is no longer relevant. There is already a final HIPAA privacy rule.
D-250.988	Support Progress of Science by Addressing Travel Visa Problems	<p>Our AMA will send a letter to the US Department of State explaining the negative impact current visa practices are having on medical and scientific progress and urging policy changes that remove unnecessary barriers in the business and travel visa process that prevent international physicians and scientists seeking to attend US-based medical and scientific conferences.</p> <p>Citation: (Res. 214, I-11)</p>	Retain – this policy remains relevant.
D-265.999	The Right to Know Your Accuser	<p>Our AMA will institute all possible measures on a national level to allow physicians who are subjected to investigations by federal agencies to know their accusers.</p> <p>Citation: (Resolution 220, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Rescind. This policy has been accomplished. Our AMA wrote a letter to CMS commenting on the new suspension of payment standards. CMS has defined a credible allegation of fraud as: A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline

			<p>complaints. (2) Claims data mining. (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency (SMA) has reviewed all allegations, facts, and evidence carefully; and acts judiciously on a case-by-case basis.</p> <p>An allegation is now considered credible if the SMA finds that the allegation has evidence of reliability after carefully reviewing all allegations, facts, and evidence. In making credibility determinations, the SMA must act judiciously on a case-by-case basis. CMS has commented that the amount of evidence necessary to support a finding of credibility under the current standard will vary depending on the facts and circumstances surrounding each allegation.</p>
D-270.988	AMA Improve its Transparency, Accountability and Communication	<p>Our AMA will proactively improve its transparency, accountability, and communication by providing rationale for positions to constituent societies and members regarding its actions pertaining to all health care legislation.</p> <p>Citation: (Res. 210, A-11)</p>	Retain – this policy remains relevant.
D-275.964	Principles of Due Process for Medical License Complaints	1. Our AMA will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician’s medical license, including strong protections for physicians’ rights.	Retain – this policy remains relevant.

		<p>2. Our AMA takes the position that: A) when a state medical board conducts an investigation or inquiry of a licensee applicant’s quality of care, that the standard of care be determined by physician(s) from the same specialty as the licensee applicant, and B) when a state medical board conducts an investigation or inquiry regarding quality of care by a medical licensee or licensee applicant, that the physician be given: (i) a minimum of 30 days to respond to inquiries or requests from a state medical board, (ii) prompt board decisions on all pending matters, (iii) sworn expert review by a physician of the same specialty, (iv) a list of witnesses providing expert review, and (v) exculpatory expert reports, should they exist.</p> <p>Citation: (Res. 238, A-08; Appended: Res. 301, A-11)</p>	
D-315.981	National Master Patient Identifier	<p>Our AMA, along with other stakeholders, will work with the Office of the National Coordinator for Health Information Technology to develop a strategy for patient identification system at the national level.</p> <p>Citation: (BOT Rep. 23, A-10)</p>	Retain – this policy remains relevant.
D-315.992	Police, Payer and Government Access to Patient Health Information	<p>Our AMA will: (1) widely publicize to our patients and others, the risk of uses and disclosures of individually identifiable health information by payers and health plans, without patient consent or authorization, permitted under the final Health Insurance Portability and Accountability Act “privacy” rule; and (2) continue to aggressively advocate to Congress, and the Administration, physician’s concerns with the administrative simplification provisions of HIPAA and that the AMA seek changes, including legislative relief if necessary, to reduce the administrative and cost burdens on physicians.</p> <p>Citation: (Res. 246, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
D-330.922	Competitive Bidding for Purchase of Medical Equipment by Centers for Medicare and Medicaid Services	<p>Our AMA will: (1) lobby in favor of modification of current Centers for Medicare & Medicaid Services policy to ensure that payments for medical technologies are comparable to market rates; and (2) lobby in favor of moving ahead with the Centers for Medicare & Medicaid Services’ plans for a competitive bidding process for home medical equipment and encourage CMS to take into</p>	<p>Rescind. This policy has been accomplished.</p> <p>Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the DMEPOS CBP was to be</p>

		<p>consideration quality and patient convenience, in addition to cost.</p> <p>Citation: (Res. 814, I-08; Reaffirmed in lieu of Res. 201, I-11)</p>	<p>phased-in so that competition under the program would first occur in 10 MSAs in 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made certain limited changes. In accordance with MIPPA, CMS successfully implemented the Round 1 Rebid in 2011 in select markets and expanded in 2013 for a total of 130 CBAs. After recompeting DMEPOS CBP contracts in these markets, CMS announced plans for Round 2019 in all 130 CBAs. In February 2017, CMS announced that Round 2019 was delayed to allow for reforms to the DMEPOS CBP.</p> <p>Round 2021 of the DMEPOS Competitive Bidding Program began on January 1, 2021 and extends through December 31, 2023. Round 2021 consolidates the CBAs that were included in Round 1 2017 and Round 2 Recompete. Round 2021 includes 130 CBAs.</p> <p>https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid</p>
D-330.969	Opposition to Mandatory Hospitalization Prior to Nursing Home Placement	Our AMA shall inform the Centers for Medicare & Medicaid Services that the regulation concerning mandatory hospitalization prior to skilled nursing home placement for Medicare beneficiaries is	Rescind. Our AMA has completed this directive and has more recent and broad policy, including

		<p>obsolete, wasteful of valuable resources and should be abolished.</p> <p>Citation: (Res. 139, A-02; Reaffirmed: Res. 234, A-09; Reaffirmation A-11)</p>	<p>H-280.947, Three Day Stay Rule; H-280.950, Medicare’s Three-Day Hospital Stay Requirement.</p>
D-330.979	<p>Medicare Reimbursement for Vitamin D Therapy for Dialysis Patients</p>	<p>Our AMA will petition the Centers for Medicare & Medicaid Services and/or lobby Congress to defeat the “Vitamin D Analogs Draft Local Medical Review Policy” and to prevent its implementation in Florida or any other state.</p> <p>Citation: (Res. 134, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	<p>Retain – this policy remains relevant.</p>
D-335.994	<p>Medical Necessity Determinations under Medicare</p>	<p>Our AMA will urge the Centers for Medicare & Medicaid Services and Congress that medical necessity denials within the Medicare program be reviewed by a physician of the same specialty and licensed in the same state.</p> <p>Citation: (Sub. Res. 713, A-01; Reaffirmed: CMS Rep. 7, A-11)</p>	<p>Rescind. This policy has been accomplished. Multiple letters were written to relevant stakeholders (letter 1; letter 2; letter 3) encouraging physician review of medical necessity denials.</p>
D-35.983	<p>Addressing Safety and Regulation in Medical Spas</p>	<p>Our AMA will: (1) advocate for state regulation to ensure that cosmetic medical procedures, whether performed in medical spas or in more traditional medical settings, have the same safeguards as “medically necessary” procedures, including those which require appropriate training, supervision and oversight; (2) advocate that cosmetic medical procedures, such as botulinum toxin injections, dermal filler injections, and laser and intense pulsed light procedures, be considered the practice of medicine; (3) take steps to increase the public awareness about the dangers of those medical spas which do not adhere to patient safety standards by encouraging the creation of formal complaint procedures and accountability measures in order to increase transparency; and (4) continue to evaluate the evolving issues related to medical spas, in conjunction with interested state and medical specialty societies.</p> <p>Res. 209, I-11</p>	<p>Retain – this policy remains relevant.</p>
D-35.986	<p>Encouraging the AMA to Ask the Robert Wood Johnson Foundation to Substantiate Report Findings</p>	<p>Our AMA will request that the Robert Wood Johnson Foundation: 1) reevaluate the role of advanced practice nurses in the context of a physician-led, patient-centered medical home model; 2) consider the current demographic distribution of advanced practice nurses in independent practice states as an indicator that</p>	<p>Rescind. Our AMA continues to support physician-led teams; created the GEOMAPS (2008, 2014, 2018, 2020) and Health Workforce Mapper to show</p>

	Regarding Nurse Practitioners	<p>there are no true market barriers to competition in health care, rather there are other factors that influence where advanced practices nurses and doctors practice; and 3) require the accuracy of scientific control measures when comparing outcomes of two different care groups, nurse practitioners and physicians.</p> <p>Citation: (Res. 232, A-11)</p>	<p>distribution of non-physicians compared to physicians; continues to urge lawmakers to rely on fact-based data when considering scope expansions.</p>
D-350.988	American Indian/ Alaska Native Adolescent Suicide	<p>Our AMA will: 1) provide active testimony in Congress for suicide prevention and intervention resources to be directed towards American Indian/Alaska Native communities; 2) encourage significant funding to be allocated to research the causes, prevention, and intervention regarding American Indian/Alaska Native adolescent suicide and make these findings widely available; and 3) lobby the Senate Committee on Indian Affairs on the important issue of American Indian/Alaska Native adolescent suicide.</p> <p>Citation: (Sub Res. 404, A-11)</p>	<p>Retain – this policy remains relevant.</p>
D-373.996	Possible HIPAA Violations by Law Firms	<p>Our AMA will encourage the Office for Civil Rights of the Department of Health and Human Services to investigate the activities of entities, including Consumer Injury Alert, with regard to possible Health Insurance Portability and Accountability Act (HIPAA) violations and solicitations of lawsuits, and to take whatever action may be legally permissible and fiscally affordable to stop such possible violations and solicitations.</p> <p>Citation: (Res. 217, I-11)</p>	<p>Retain – this policy remains relevant.</p>
D-375.988	Local Peer-Review and Physician Sponsorship Requirements from Medicare QIO Work	<p>Our AMA supports efforts in Congress to reverse the Medicare QIO program structure changes in HR 2832 related to physician involvement in state level QIO work, maintain the statewide scope of QIO contracts, assure the continuation of the beneficiary complaint process and quality improvement efforts at the state level, and maintain the essential local relationships that QIOs must have with physicians and other providers.</p> <p>Citation: (Res. 832, I-11)</p>	<p>Retain – this policy remains relevant.</p>
D-375.991	IOM Report on QIO Program	<p>Our AMA will advocate that: (a) the medical review duties currently included in the Medicare Quality Improvement Organization (QIO) scope of work continue to remain the responsibility of the federally designated QIO in each state through the</p>	<p>Retain – this policy remains relevant.</p>

		<p>end of the current Eighth Scope of Work on into the Ninth Scope of Work and beyond; and (2) medical review of physicians continue to be performed by physicians taking into account both cultural competency and local conditions.</p> <p>Citation: (Res. 726, A-06; Reaffirmed: Res. 832, I-11)</p>	
D-375.998	Peer Review Protection for Physicians Covered by the Federal Tort Claims Act	<p>Our AMA will work with the Indian Health Service headquarters, Public Health Service, and the Department of Health and Human Services Office of the General Counsel to enact federal legislation protecting the confidentiality of peer review/clinical quality assurance information done by physicians and organizations covered by the Federal Tort Claims Act.</p> <p>Citation: (Res. 230, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
D-375.999	Confidentiality of Physician Peer Review	<p>Our AMA will draft and advocate for legislation amending, as appropriate: (1) the Freedom of Information Act to exempt confidential peer review information from disclosure under the Act; and (2) the Health Care Quality Improvement Act to prohibit discovery of information obtained in the course of peer review proceedings.</p> <p>Citation: (BOT Rep. 22, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
D-385.962	AMA Statement to FTC, CMS and OIG DHHS Supporting the Ability of ACOs to Negotiate with Insurers on an Exclusive Basis	<p>Our AMA will clarify its support of antitrust relief for physician-led accountable care organizations (ACOs), as stated in its September 27, 2010 statement to the Federal Trade Commission, the Centers for Medicare & Medicaid Services, and the Office of Inspector General of the US Department of Health and Human Services, as being limited to physician-led ACOs and not to ACOs owned and controlled by non-physicians, including hospitals, insurance companies, or others.</p> <p>Citation: (Res. 830, I-10; Reaffirmed: Res. 215, A-11)</p>	<p>Rescind. This policy has been accomplished.</p> <p>https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Faco-antitrust-reform-proposal-comment-letter.pdf</p>
D-390.957	A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act	<p>Our AMA will now initiate and sustain our well-funded grassroots campaign to secure the support of the American People for passage of the Medicare Patient Empowerment Act in Congress as directed by the 2010 Interim Meeting of the House of Delegates through AMA Policy D-390.960.</p> <p>Citation: (Res. 203, I-11)</p>	Retain – this policy remains relevant.

D-435.970	Expert Witness Certification	<p>1. Our AMA will immediately assist all interested state medical associations in initiating similar legislation as recently passed in Florida to require physicians licensed in another state to obtain an expert witness certificate before being able to provide expert witness testimony in medical liability actions, and that state physician licensing boards be empowered to discipline any expert witness, both those licensed in that state and those with an expert witness certificate, who provide deceptive or fraudulent expert witness testimony.</p> <p>2. Our AMA will continue to provide updates on our AMA Web site regarding the progress that has occurred in the implementation of expert witness legislation in states throughout the United States.</p> <p>Citation: (Res. 203, A-11)</p>	Retain – this policy remains relevant.
D-440.939	National Diabetes Clinical Care Commission	<p>Our AMA will actively work to secure congressional enactment of a National Diabetes Clinical Care Commission.</p> <p>Citation: (Res. 223, I-11)</p>	Rescind. This policy has been accomplished. The National Clinical Care Commission Act (Pub. L. 115–80) required the HHS Secretary to establish the National Clinical Care Commission, which has conducted activities since 2018.
D-450.966	American Health Care Access, Innovation, Satisfaction and Quality	<p>Our AMA will begin an international comparative study on health care quality that is a comprehensive and balanced study including comparisons of patient satisfaction, cancer outcomes, outcomes among more severe illnesses and injuries, rapidity of access and patient satisfaction as end points, and present their findings to the AMA House of Delegates at the 2012 Annual Meeting.</p> <p>Citation: (Res. 104, A-11)</p>	Rescind. Aspects of this policy continue to be addressed in articles published in JAMA, Health Affairs, Kaiser Family Foundation, World Health Organization, and several other sources.
D-460.972	Creation of a National Registry for Healthy Subjects in Phase I Clinical Trials	<p>Our AMA encourages the development and implementation of a national registry, with minimally identifiable information, for healthy subjects in Phase 1 trials by the US Food and Drug Administration or other appropriate organizations to promote subject safety, research quality, and to document previous trial participation.</p> <p>Citation: (Res. 913, I-11)</p>	Retain – this policy remains relevant.

D-460.973	Comparative Effectiveness Research	<p>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.</p> <p>Citation: (Res. 221, A-11)</p>	Retain – this policy remains relevant.
D-478.979	Promoting Internet-Based Electronic Health Records and Personal Health Records	<p>Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR.</p> <p>Citation: (BOT Rep. 11, I-11)</p>	Rescind. Most people are not using PHRs in the way envisioned when this policy was first adopted. The movement now is for smartphone apps to essentially function as PHRs. In that sense, our AMA continues to work with multiple agencies to minimize risks, educate about implementation barriers, and promote best practices, etc., more focused on apps rather than other types of PHRs.

G-615.070	COL Activities	<p>AMA policy on the activities of the Council on Legislation include the following: (1) All medical legislative issues should be cleared through the COL before action is taken by any other AMA council or committee, and the Board shall take whatever action is appropriate to achieve this objective;</p> <p>(2) The Council shall continue to refer issues to other committees and councils for advice and recommendations, when said issues properly fall within their sphere of knowledge and activities;</p> <p>(3) The Board shall be advised of the Council’s desire to maintain constant surveillance of legislative matters;</p> <p>(4) The Council shall have authority to recommend to the Board the initiation of specific legislation or legislative policy to meet current problems confronting physicians or our AMA; and</p> <p>(5) The Board shall be advised of the Council’s willingness and ability to testify before congressional committees or to accompany the principal witnesses who may testify on behalf of the Association.</p> <p>Citation: (COL/BOT Rec., I-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: CC&B Rep. 2, A-11)</p>	Retain – this policy remains relevant.
H-120.951	Mandatory Acceptance of the Currently Utilized Physician Prescription Form by Pharmacy Benefit Plan Administration	<p>Our AMA seeks legislation or regulation that would: (1) require that pharmacy benefits plans accept the currently utilized physician prescription forms for all initial prescriptions and renewals; and (2) ensure that a written, oral or electronically transmitted prescription that complies with state and federal law constitutes the entirety of the physician’s responsibility in providing patient prescriptions.</p> <p>Citation: (Res. 516, A-02; Reaffirmed: BOT Rep. 8, A-11)</p>	Retain – this policy remains relevant.
H-120.999	Refilling of Prescriptions	<p>The AMA supports pursuing through the proper state or federal enforcement agencies full compliance with the laws, and if no law applies, supports legislation to carry out the following criteria: (1) any prescription not labeled as to number of refills may not be refilled; and (2) any prescription labeled PRN or ad lib may not be refilled.</p>	Retain – this policy remains relevant.

		Citation: (Res. 46, A-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 8, A-11)	
H-150.998	Food Additives	<p>Our AMA supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market.</p> <p>Citation: (Sub. Res. 4, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 6, A-10)</p>	Retain – this policy remains relevant.
H-160.929	Anesthesiology is the Practice of Medicine	<p>It is the policy of the AMA that anesthesiology is the practice of medicine. Our AMA seeks legislation to establish the principle in federal and state law and regulation that anesthesia care requires the personal performance or supervision by an appropriately licensed and credentialed doctor of medicine, osteopathy, or dentistry.</p> <p>Citation: (Sub. Res. 216, I-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: BOT Rep. 9, I-11)</p>	Retain – this policy remains relevant.
H-175.973	Medicare Investigation Search and Seizure Process	<p>(1) It is the policy of our AMA that: (1) no duly authorized law enforcement or legal agency conduct any unannounced search of physicians' offices or seizure of records without observance of appropriate legal procedures;</p> <p>(2) should unannounced search and seizure procedures be warranted in emergency situations based on clear and immediate threats to the lives or physical well-being of patients or the general public, such searches/seizures be conducted within the following parameters: (a) the search and/or seizure shall be conducted in a non-threatening and thoroughly professional manner; (b) the search and/or seizure shall not disrupt patient care; (c) the search and/or seizure shall be conducted in a manner to avoid publicity injurious to a physician's practice and professional reputation until all facts are known and culpability, if any, can be proven;</p> <p>(3) When an episode occurs whereby a governmental agency disrupts the daily activities of a physician's office in the process of investigating alleged fraud and abuse activities, that such</p>	Retain – this policy remains relevant. Update Clause 3 so reports are directed to the AMA Advocacy unit since there is no longer a separate Division of Private Sector Advocacy.

		<p>episodes be reported to the Division of Private Sector AMA Advocacy unit for tracking purposes and to assist the involved/affected physician(s); and.</p> <p>(4) If abusive practices of the investigative agency are noted, the AMA will inform the Department of Justice of those tactics.</p> <p>Citation: (Res. 205, I-01; Reaffirmed: BOT Rep. 22, A-11)</p>	
H-175.977	Disruptive Visits to Medical Offices by Government Investigators and Agents	<p>Our AMA: (1) supports legislation and/or other appropriate means to ensure that State and Federal investigators, and/or agents, give a physician written notice prior to a visit to a medical office, so that such visit may be scheduled upon mutual agreement at a time when patients are not present in the medical office; (2) in any circumstances which lawfully permit a visit to a medical office without notice, such as a search warrant, arrest warrant or subpoena, investigators and/or agents should be required to initially identify themselves to appropriate medical staff in a quiet and confidential way that allows the physician an opportunity to comply in a manner that is least disruptive and threatening to the patients in the medical office; and (3) encourages physicians to report incidents of inappropriate intrusions into their medical offices to the AMA's Office of the General Counsel and consider development of a hotline for implementation.</p> <p>Citation: (Res. 211, A-99; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
H-175.979	Medicare “Fraud and Abuse” Update	<p>Our AMA seeks congressional intervention to halt abusive practices by the federal government and refocus enforcement activities on traditional definitions of fraud rather than inadvertent billing errors.</p> <p>Citation: (BOT Rep. 34, I-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
H-175.981	Fraud and Abuse Within the Medicare System	<p>(1) Our AMA stands firmly committed to eradicate true fraud and abuse from within the Medicare system. Furthermore, the AMA calls upon the DOJ, OIG, and CMS to establish truly effective working relationships where the AMA can effectively assist in identifying, policing, and deterring true fraud and abuse.</p>	Retain – this policy remains relevant.

		<p>(2) Physicians must be protected from allegations of fraud and abuse and criminal and civil penalties and/or sanctions due to differences in interpretation and or inadvertent errors in coding of the E&M documentation guidelines by public or private payers or law enforcement agencies.</p> <p>(3) The burden of proof for proving fraud and abuse should rest with the government at all times.</p> <p>(4) Congressional action should be sought to enact a “knowing and willful” standard in the law for civil fraud and abuse penalties as it already applies to criminal fraud and abuse penalties with regard to coding and billing errors and insufficient documentation.</p> <p>(5) Physicians must be accorded the same due process protections under the Medicare audit system or Department of Justice investigations, that are afforded all US citizens.</p> <p>Citation: (Sub. Res. 801, A-98; Reaffirmed: Res. 804, I-98; Reaffirmed: BOT Rep. 6, A-00; Reaffirmation I-01; Modified: CMS Rep. 7, A-11)</p>	
<p>H-175.987</p>	<p>All-Payer Health Care Fraud and Abuse Enforcement Program</p>	<p>Our AMA: (1) opposes an All-Payer Health Care Fraud and Abuse Enforcement Program described in the Health Security Act of 1993 as it specifically applies to the seizure of property as a punitive measure in health care fraud cases; (2) supports efforts to clearly define health care fraud and establish an intergovernmental commission to investigate the nature, magnitude and costs involved in health care fraud and abuse; and (3) will pursue enactment of laws that ensure the equal application of due process rights to physicians in health care fraud prosecution.</p> <p>Citation: (Res. 215, A-94; Reaffirmation A-99; Reaffirmation I-00; Reaffirmation I-00; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)</p>	<p>Rescind. The Health Security Act of 1993, S. 491, was introduced but never passed. However, Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a comprehensive program to combat fraud committed against all health plans, both public and private. The legislation required the establishment of a national Health Care Fraud and Abuse Control Program (HCFAC), under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS)</p>

			acting through the Department's Inspector General (HHS/OIG). The HCFAC program is designed to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse.
H-180.955	Deductibles Should Be Prorated to Make Them Equitable for Enrollees	Our AMA seeks legislation, regulation or other appropriate relief to require insurers to prorate annual deductibles to the date of contract enrollment. Citation: (Res. 235, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
H-190.961	Repeal of Federally Mandated Uniform Medical Identifiers	Our AMA: (1) actively supports legislation that would repeal the unique patient medical health identifier mandated by the Health Insurance Portability and Accountability Act of 1996; and (2) urges all state medical societies to ask each of their congressional delegations to declare themselves publicly on this matter. Citation: (Res. 207, I-01; Reaffirmed: BOT Rep. 22, A-11)	Rescind. Policy D-315.981 , National Master Patient Identifier, is recommended to be retained (see above) and more broadly calls for our AMA to develop a strategy for a patient identification system at the national level.
H-215.962	Maintain CMS Inpatient Rehabilitation Classification Criteria at 60%	Our AMA: (1) reaffirms existing AMA policy and supports continuation of the compliance threshold for inpatient rehabilitation hospitals at its current level of 60 percent; and (2) strongly opposes any increase in the compliance threshold for inpatient rehabilitation hospitals. Citation: (Res. 212, I-11)	Retain – this policy remains relevant.
H-240.960	Opposition to Equalization of Payment Rates for Inpatient Rehabilitation Facilities and Skilled Nursing Facilities	Our AMA will oppose legislative or regulatory efforts to equalize payments for more medically complex rehabilitation patients with greater functional deficits, who require more intensive rehabilitation in an Inpatient Rehabilitation Facility, compared to less medically complex rehabilitation patients with fewer functional deficits, who require less intensive rehabilitation at a Skilled-Nursing Facility, regardless of their specific medical diagnosis. Citation: (Res. 213, I-11)	Retain – this policy remains relevant.
H-270.956	Evidence-Based Standard Requirement for	Our AMA supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate	Retain – this policy remains relevant.

	Governmental Regulation	<p>the benefit of existing regulations and new regulations within three years of implementation; and that the demonstration of benefit must employ evidence-based standards of care; and that any regulations that do not show measurable improved patient outcomes must be revised or rescinded.</p> <p>Citation: (BOT Rep. 7, A-11)</p>	
H-270.964	Fraud Compliance and Compliance Plans	<p>Our AMA express its strong objections to the OIG for its unwarranted punitive attitude and the financial and administrative burden to physician practices and seeks modification to the final version of the “Office of Inspector General’s Compliance Program Guidance for Individual and Small Group Physician Practices” so that it is not burdensome nor costly to medical practices (with respect to physician, staff, administrative, and financial resources) and focuses on education rather than criminal punishment.</p> <p>Citation: (BOT Rep. 29, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	<p>Rescind. Our AMA is, and will continue to, engage with the OIG to oppose policies that negatively impact individual and small group physician practices. The Office of Inspector General’s Compliance Program Guidance for Individual and Small Group Physician Practices” is no longer on the OIG website, and has been replaced by a “Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud Abuse.” Although the guidance document does provide information on penalties, the tone is more focused on education.</p>
H-270.999	Legislation Making the Federal Register Give Fairer and More Reasonable Notice of the Promulgation of Regulations Which Will Have the Force of Law	<p>Our AMA (1) is concerned over the lack of opportunity to develop and submit appropriate comments on proposed regulations, especially in the Federal Register, without adequate notice; and (2) supports (a) taking appropriate action to obtain greater advance notice and opportunity to comment on proposed regulations; (b) consideration of appropriate means to make available for the profession information concerning significant proposals of the various federal agencies on health matters; and (c) development of mechanisms to provide for more effective relief from the implementation of regulations harmful to sound medical practice should comments adverse to such regulations be ignored.</p> <p>Citation: (Sub. Res. 152, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report,</p>	<p>Retain – this policy remains relevant.</p>

		A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)	
H-285.939	Managed Care Medical Director Liability	<p>AMA policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. (1) Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions; (2) that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services; and (3) that our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.</p> <p>Citation: (Sub. Res. 202, A-98; Appended: Res. 201, I-98; Reaffirmation A-99; Reaffirmed: BOT Rep. 18, I-00; Reaffirmation A-07; Reaffirmed in lieu of Res. 235, A-11: BOT action in response to referred for decision Res. 235, A-11)</p>	Retain – this policy remains relevant.
H-290.977	Medicaid Sterilization Services Without Time Constraints	<p>Our AMA will pursue an action to amend federal Medicaid law and regulations to remove the time restrictions on informed consent, and thereby allow all patients, over the age of 21 and legally competent, to choose sterilization services.</p> <p>Citation: (Res. 226, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
H-295.947	Legislative Threats to the Voluntary Accreditation Process	<p>It is the policy of the AMA to strongly oppose legislation which would: (1) dismantle national accrediting agencies and which would substitute state standards for a uniform level of national standards in medical education; and (2) limit professional participation in the setting and evaluation of quality standards in medical education.</p> <p>Citation: (Res. 225, I-91; Modified: Sunset Report, I-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.

H-305.962	Taxation of Federal Student Aid	<p>Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA).</p> <p>Citation: (Res. 210, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)</p>	Retain – this policy remains relevant.
H-305.997	Income Tax Exemption for Medical Student Loans and Scholarships	<p>The AMA supports continued efforts to obtain exemption from income tax on amounts received under medical scholarship or loan programs.</p> <p>Citation: (Res. 65, I-76; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CME Rep. 2, A-11)</p>	Rescind. This issue is addressed in H-305.962 , Taxation of Federal Student Aid.
H-330.918	Violation of Medicare Act	<p>Our AMA will take all measures to oppose any provision in the Medicare law and regulations that permits inappropriate federal involvement in medical treatment decisions or control over the practice of medicine as prohibited by Section 1801 of the Social Security Act.</p> <p>Citation: (BOT Rep. 37, I-98; Reaffirmation A-99; Reaffirmed: Res. 217, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
H-330.943	Physicians' Rights	<p>Our AMA: (1) in conjunction with CMS, will seek to develop a simple, straightforward statement of a health care professional's or a provider's rights when initially under investigation for alleged fraud or abuse; and (2) urges that, where records or other information are requested from hospitals or other sources by a Medicare carrier fraud and abuse unit and where the investigation does not yield a potential case referable to the Office of the Inspector General, those sources from which information was sought and the involved physicians and others should be notified of their absolution after such an investigation.</p> <p>Citation: (Substitute Res. 212, I-94; Reaffirmation A-99; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)</p>	Retain – this policy remains relevant.
H-330.948	Three Day Prior Hospital Stay Requirement	<p>Our AMA will recommend that the Secretary of the U.S. Department of Health and Human Services, in consultation with health care professionals and skilled care providers, define a subset of patients (or DRGs) for whom the elimination of the three-day prior hospital stay requirement for eligibility of the Medicare Skilled Nursing Facility benefit would avert hospitalization and generate overall cost savings.</p>	Rescind. This policy is not relevant as our AMA has advocated more broadly to eliminate the three-day hospital stay requirement for SNFs.

		Citation: (Res. 805, I-93; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-04; Reaffirmed: Res. 234, A-09; Reaffirmation A-11)	
H-330.964	Federal Budgetary Process Reform as It Affects Medicare	Our AMA seeks legislative reform of the federal budgetary process to remove last-minute changes in Medicare funding in the reconciliation budget process and to insure appropriate and timely public input. Citation: (Res. 177, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-330.988	Free Choice by Patient and Physician Guaranteed	Our AMA reaffirms the original intent of Title XVIII, Section 1802 of the Social Security Act, which guarantees free choice by patient and physician. Citation: (Res. 115, I-87; Reaffirmed: Res. 731, A-95; Reaffirmed: Res. 217, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-335.962	Recovery Audit Contractors Should Confirm Problem Has Not Already Been Resolved Before Undertaking an Audit	Our AMA advocates that Federal Recovery Audit Contractors (RACs), prior to instituting an audit of a physician practice, make a good faith effort to ascertain whether the practice has already self-identified any billing irregularities that may have resulted in overpayments (including any such overpayment that may have been reported to the RAC), and has satisfactorily cured the irregularities by returning the overpayments and making any needed changes in their billing procedures, and where such self-identification and rectification has already occurred, that the audit not be initiated. Citation: (Res. 214, A-11)	Retain – this policy remains relevant.
H-335.984	Medicare Regulatory Relief Legislation	It is the policy of the AMA to initiate modifications to the Regulatory Relief Amendments or introduce additional legislation to address further areas where unwieldy or inequitable federal regulations or legislation place unrealistic or unfair demands on physicians and their office staff to: (1) abolish the A/B Data Link in which physician services provided during inpatient treatment, where payment to the hospital has been denied, are reviewed and can be denied as medically unnecessary years after the treatment has been provided; (2) abolish the practice of downcoding claims where Medicare carriers arbitrarily alter physician claims so that physicians are paid for a lower level of service than the one actually provided;	Retain – this policy remains relevant.

		<p>(3) further clarify Section 6109 of OBRA 1989 that nullified the recoupment of funds from Texas physicians and patients so that the original intent of the legislation would be realized through repayment of funds to those physicians and beneficiaries who had already repaid funds to the government;</p> <p>(4) include provisions that relieve patients and physicians of responsibility for implementation of the Medicare as a Secondary Payer provisions and that the Medicare carrier be charged with responsibility for obtaining payment from the proper insurer rather than from physicians or beneficiaries for any errors that may be made in the determination of a beneficiary's insurance status; and</p> <p>(5) include provisions that would nullify Section 6102(g)(4) of OBRA 1989 that all Medicare claims be filed by physicians so that physicians who have large numbers of claims for small amounts would not be burdened with the transaction costs of meeting the mandatory claims filing provision, particularly since the OBRA 1989 provisions explicitly forbid physicians from requesting or receiving any additional payment for this costly and time-consuming service.</p> <p>Citation: (Res. 213, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)</p>	
<p>H-340.900</p>	<p>Quality Improvement Organization Program Status</p>	<p>Our AMA urges implementation of a Medicare beneficiary complaint process under the Medicare Quality Improvement Organization Program that meets the information needs of patients, offers appropriate due process for physicians, and maintains confidentiality of review findings.</p> <p>Citation: (CMS Rep. 1, A-97; Reaffirmation A-01; Modified: CMS Rep. 7, A-11)</p>	<p>Retain – this policy remains relevant.</p>
<p>H-340.917</p>	<p>Publication in Federal Register of Proposed Changes in QIO Review Process or Procedures</p>	<p>Our AMA strongly urges CMS to publish in the Federal Register for review and comment any significant proposed changes in the quality improvement organization (QIO) process or procedures which would affect physician practice patterns and/or the delivery of medical care.</p> <p>Citation: (Sub. Res. 710, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)</p>	<p>Retain – this policy remains relevant.</p>

H-340.930	<u>Peer Review Quality Improvement Organization Sanctions</u>	<p>Our AMA supports vigorously pursuing with appropriate peer review<u>quality improvement</u> organizations (1) the careful definition of an adverse event, (2) the identification of whether the event is avoidable or unavoidable and whether it is a recognized complication of diagnosis or treatment, and (3) whether the event establishes a pattern or trend pointing to inappropriate physician or institutional behavior.</p> <p>Citation: (Res. 185, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)</p>	<p>Retain part of the policy.</p> <p>The Medicare Peer Review Organization program was renamed the Quality Improvement Organization program. Modify the title and policy by replacing “peer review” with “quality improvement.”</p>
H-340.931	Unannounced Enforcement of Regulation	<p>Our AMA petitions CMS to preclude application of a law, rule or regulation prior to its effective date and urges CMS to announce the date on which the enforcement of a law, rule or regulation applicable to the Medicare program will begin.</p> <p>Citation: (Res. 199, A-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)</p>	<p>Retain – this policy remains relevant.</p>
H-340.932	Time Restrictions Placed on QIOs to Implement Changes in Review Procedures	<p>Our AMA supports working with CMS to assure that quality improvement organizations are given adequate time for proper implementation of mandated changes to review processes and procedures.</p> <p>Citation: (Res. 95, A-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)</p>	<p>Retain – this policy remains relevant.</p>
H-340.933	QIO Data Dissemination	<p>Our AMA discourages the use of any QIO data by any hospital, medical staff or other body for credentialing purposes.</p> <p>Citation: (Res. 249, A-91; Modified: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)</p>	<p>Retain – this policy remains relevant.</p>
H-340.972	Office of the Inspector General Involvement in <u>Peer Review Quality Improvement</u>	<p>The AMA supports (1) careful review of the involvement of the Office of Inspector General in peer review<u>quality improvement</u> organization and other sanction activity against physicians based on the quality of care provided; and (2) taking all appropriate steps, including legislative action if necessary, to establish a fair review mechanism designed to ensure that quality of care determinations are medically correct.</p> <p>Citation: (Res. 67, I-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 7, A-11)</p>	<p>Retain part of the policy.</p> <p>The Medicare Peer Review Organization program was renamed the Quality Improvement Organization program. Modify the title and policy by replacing “peer review” with “quality improvement.”</p>

H-35.970	Doctor of Nursing Practice	<p>1. Our American Medical Association opposes participation of the National Board of Medical Examiners in any examination for Doctors of Nursing Practice (DrNP) and refrain from producing test questions to certify DrNP candidates.</p> <p>2. AMA policy is that Doctors of Nursing Practice must practice as part of a medical team under the supervision of a licensed physician who has final authority and responsibility for the patient.</p> <p>Citation: (Res. 214, A-08; Reaffirmed: BOT Rep. 9, I-11)</p>	Retain – this policy remains relevant.
H-35.973	Scopes of Practice of Physician Extenders	<p>Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.</p> <p>Citation: (Res. 213, A-02; Reaffirmed: BOT Rep. 9, I-11)</p>	Retain – this policy remains relevant.
H-35.974	Prescribing by Allied Health Practitioners	<p>Our AMA will work with national specialty societies to monitor the status of any initiatives to introduce legislation that would permit prescribing by psychologists and other allied health practitioners, and develop in concert with state medical associations specific strategies aimed at successfully opposing the passage of any such future legislation.</p> <p>Citation: (Sub. Res. 203, A-02; Reaffirmed: BOT Rep. 9, I-11)</p>	Retain – this policy remains relevant.
H-35.982	Direct Access to Physical Therapy	<p>Our AMA (1) affirms that the ordering of medical services for patients constitutes the practice of medicine and that legislation to authorize non-physicians to prescribe physical therapy and other medical care services should be opposed; and (2) encourages physicians who prescribe physical therapy to closely monitor their prescriptions to ensure that treatment is appropriate.</p> <p>Citation: (Res. 203, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: Res. 224, A-11)</p>	Retain – this policy remains relevant.

<p>H-35.993</p>	<p>Opposition to Direct Medicare Payments for Physician Extenders</p>	<p>Our AMA reaffirms its opposition to any legislation or program which would provide for Medicare payments directly to physician extenders, or payment for physician extender services not provided under the supervision and direction of a physician.</p> <p>Citation: (CMS Rep. N, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11)</p>	<p>Retain – this policy remains relevant.</p>
<p>H-355.979</p>	<p>National Practitioner Data Bank</p>	<p>It is policy of the AMA to improve patient access to reliable information and as an alternative to a federally operated national data repository, our AMA strongly supports and actively encourages the provision of accurate and relevant physician-specific information through a system developed and operated by state licensing boards or other appropriate state agencies</p> <p>Our AMA: (1) supports requiring felony convictions of physicians to be reported to state licensing boards; (2) supports federal block grants that provide states with sufficient financial resources to develop and implement officially recognized, Internet accessible, physician-specific information systems that will assist patients in choosing physicians; and (3) believes that serious problems exist in correlating lawsuits with physician competence or negligence and some studies indicate lawsuits seldom correlate with findings of incompetence. Only a state licensing board should determine when lawsuit settlements and judgments should result in a disciplinary action, and public disclosure of lawsuit settlements and judgments should only occur in connection with a negative state medical board licensing action.</p> <p>Citation: (BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01; Reaffirmed: CME Rep. 2, A-11)</p>	<p>Retain – this policy remains relevant.</p>
<p>H-365.986</p>	<p>US Efforts to Address Health Problems Related to Agricultural Activities</p>	<p>Our AMA supports the endeavors of the U.S. Surgeon General and the National Institute of Occupational Safety and Health of CDC to address health problems related to agricultural activities.</p> <p>Citation: (Res. 212, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)</p>	<p>Retain – this policy remains relevant.</p>
<p>H-385.918</p>	<p>Urging CMS to Direct Carriers</p>	<p>Our AMA will: (1) urge the Centers for Medicare & Medicaid Services to direct its carriers to effect</p>	<p>Rescind. This policy has been accomplished. Our</p>

	<p>to Effect Mass Retroactive Claims Adjustments</p>	<p>mass retrospective claims adjustments at the rates issued by Congress in the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act, and the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010; and (2) urge Medicare contractors to ensure corrected payments are issued to physicians going forward so that physicians receive the full benefit of the increased reimbursement rates as soon as possible.</p> <p>Citation: (Res. 231, I-10; Reaffirmed: Res. 216, A-11)</p>	<p>AMA repeatedly urged CMS to proceed with the retroactive processing of claims as instructed by the Affordable Care Act. As a result of AMA advocacy, CMS finally moved forward with the processing of the claims.</p>
<p>H-385.950</p>	<p>Managed Care Secondary Payers</p>	<p>Our AMA: (1) will seek regulatory changes that require all payers of secondary Medicare insurance to reimburse the co-insurance and applicable deductible obligations of Medicare beneficiaries;</p> <p>(2) will require that these co-insurance and deductible obligations cannot be waived contractually;</p> <p>(3) will develop model state legislation that would mandate that all secondary insurers to Medicare either pay their contracted physicians full Medicare deductible and coinsurance amounts regardless of whether their fee schedules are lower than Medicare, or allow physicians to bill Medicare beneficiaries directly for the full Medicare deductible and coinsurance amounts;</p> <p>(4) will consider the development of draft federal legislation to require Medicare to recognize the total coinsurance and deductible amounts facing Medicare beneficiaries in instances where Medicare provides secondary insurance coverage;</p> <p>(5) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan (not a Medigap policy) as their secondary carrier should be entitled to receive payment in full from their secondary carriers for all Medicare patient deductible and copayments without regard to the amount of the Medicare payment for the service;</p> <p>(6) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan as secondary should be entitled to receive payment in full from their secondary plans for all Medicare patient</p>	<p>Retain part of the policy.</p> <p>Delete Clause (3) and renumber Clauses 4-7 accordingly. Our AMA has developed model legislation called for in Clause (3).</p>

		<p>deductibles and copayments without regard to any requirement that there be prior authorization by the secondary plan for medical care and treatment that is medically necessary under Medicare, by imposing limits on the amount, type or frequency of services covered, and by thereby seeking to “manage” the Medicare benefit, as if the secondary carrier were the primary carrier; and</p> <p>(76) in its advocacy efforts, will address and seek to solve (by negotiation, regulation, or legislation) the problem wherein a secondary insurance company does not reimburse the patient for, nor pay the physician for, the remainder/balance of the allowable amount on the original claim filed with the patient’s primary insurance carrier, regardless of the maximum allowed by the secondary insurance payer.</p> <p>Citation: (BOT Rep. 33, A-96; Appended: Res. 122, A-98; Reaffirmed: Res. 105, A-00; Sub. Res. 104, A-01; Reaffirmation I-01; Appended: Res. 105 and 106, A-03; Appended: Res. 821, I-11)</p>	
<p>H-390.971</p>	<p>Hospitals Limited to Participating Physicians</p>	<p>Our AMA (1) advises its members that the decision of whether or not to be a “participating” physician in Medicare is a personal choice;</p> <p>(2) supports use of all appropriate means to rescind those recently enacted regulations and statutes which unfairly discriminate against health care providers and which jeopardize the quality, availability and affordability of health care for the aged and the infirm;</p> <p>(3) urges a return to the original intent of the Medicare Law (Title XVIII) as expressed in Sections 1801 and 1802 enacted in 1965 which read as follows: “Section 1801 [42 U.S.C. 1895] Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.” “Section 1802 [42 U.S.C. 1895a] Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to</p>	<p>Retain – this policy remains relevant.</p>

		<p>participate under this title if such institution, agency, or person undertakes to provide him such services;”</p> <p>(4) supports rescinding the “incentive” in OBRA 1986 regarding hospital referral of Medicare patients to participating physicians;</p> <p>(5) supports amendment of the Medicare law to eliminate any financial incentives to Medicare carriers for signing up large numbers of physician providers; and</p> <p>(6) supports rescinding OBRA 1986 provision that requires a nonparticipating physician who performed an elective surgical procedure on an unassigned basis for a Medicare beneficiary to provide the beneficiary in writing the estimated approved charge under Medicare, the excess of the physician’s actual charge over the approved amount, and the coinsurance applicable to the procedure.</p> <p>Citation: (Res. 31, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 217, A-01; Reaffirmed: BOT Rep. 22, A-11)</p>	
H-420.978	Access to Prenatal Care	<p>(1) The AMA supports development of legislation or other appropriate means to provide for access to prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual’s economic circumstances. (2) In developing such legislation, the AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account.</p> <p>Citation: (Res. 33, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmation A-07; Reaffirmed: Res. 227, A-11)</p>	Retain – this policy remains relevant.
H-425.973	CMS Should Provide Date Eligibility Information to Beneficiaries	<p>Our AMA encourages the Centers for Medicare & Medicaid Services to establish user-friendly mechanisms, such as an automated phone-in system or a web portal, much as is currently provided by banks, including of course appropriate measures to ensure security and confidentiality, via which any Medicare beneficiary can easily and quickly verify the dates of eligibility for all preventative services to which the person is entitled.</p>	Retain – this policy remains relevant.

		Citation: (Res. 213, A-11)	
H-425.978	Stroke Prevention and Care Legislation	Our AMA supports comprehensive stroke legislation such as S.1274, the Stroke Treatment and Ongoing Prevention Act (STOP Stroke Act) as introduced, and work with Congress to enact legislation that will help improve our nation's system of stroke prevention and care. Citation: (Res. 215, I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-435.945	Binding Arbitration	Our AMA supports the utilization of pre-dispute binding arbitration that is agreed to by a patient and a physician prior to non-emergent treatment as an effective method of doctor-patient conflict resolution. Citation: (Res. 229, A-11)	Retain – this policy remains relevant.
H-435.962	Tort Reform and Managed Care	AMA policy states that medical liability reform be construed in the context of managed care and be consistent with these objectives: that (1) all managed care organizations (MCOs) are held responsible for assuring quality healthcare, and are held liable for any negligence on the part of the health plan resulting in patient injury; (2) physicians know and are able to carry out their professional obligations to patients despite cost constraints and contractual obligations to MCOs; and (3) coordinated patient safety systems tailored to managed care arrangements are in place. Citation: (BOT Rep. 18, I-96; Reaffirmation I-98; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed in lieu of Res. 224, A-09; Reaffirmed in lieu of Res. 235, A-11: BOT action in response to referred for decision Res. 235, A-11)	Retain – this policy remains relevant.
H-435.972	Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability	The AMA will continue to address the need for effective nationwide tort reform through the AMA's coalition-building activities and efforts on behalf of state and federal tort reform. Citation: (BOT Rep. M, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed in lieu of Res. 205, I-11)	Retain – this policy remains relevant.
H-435.974	Support of Campaigns Against Lawsuit Abuse	Our AMA supports expanding its tort reform activities by assisting state and county medical societies and interested civic groups in developing and implementing anti-lawsuit abuse campaigns and by encouraging members to involve themselves in these campaigns.	Retain – this policy remains relevant.

		Citation: (Res. 223, I-91; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmed: BOT Rep. 22, A-11)	
H-450.934	Timely Access to Health Insurance Plan Claims Data	Our AMA will: 1) advocate for appropriate policies, legislation, and/or regulatory action that would require third-party payers engaged in risk or incentive contracts with physician practice entities (including IPAs, PHOs, ACOs, healthcare networks, and healthcare systems) to provide physicians with timely access to reports of initial claims for service for patients served by those risk or incentive contracts; 2) advocate that third-party payers be required to make available electronically to physician practice entities reports of initial claims for service for patients served by risk or incentive contracts immediately upon such claims being received by the payer; and 3) advocate that third-party payers be required to make immediately available to physicians any relevant data on their patients collected in furtherance of risk profiling or incentive contracts that affect the safety or quality of patient care, in a form that permits efficient searching and retrieval. Citation: (Res. 220, A-11)	Retain – this policy remains relevant.
H-450.971	Quality Improvement of Health Care Services	Our AMA will continue to encourage the development and provision of educational and training opportunities for physicians and others to improve the quality of medical care. Citation: (BOT Rep. I, I-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain – this policy remains relevant.
H-460.931	Genetics Testing Legislation	The AMA opposes legislative initiatives on genetic testing that would unduly restrict the ability to use stored tissue for medical research; and will continue to support existing federal and private accreditation and quality assurance programs designed to ensure the accuracy and reliability of tests, but oppose legislation that could establish redundant or duplicative federal programs of quality assurance in genetic testing. Citation: (Sub. Res. 219, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CEJA Rep. 6, A-11)	Retain – this policy remains relevant.
H-460.953	Biomedical Research and Animal Activism	Our AMA: (1) supports working through Congress to oppose legislation which inappropriately restricts the choice of scientific animal models used in research and will work with Congress and the USDA to	Retain – this policy remains relevant.

		<p>ensure that needs and views of patients and the scientific community are heard during any further consideration of USDA's role in laboratory animal oversight; and</p> <p>(2) supports laws which make it a federal crime, and similar legislation at state levels to make it a felony, to trespass and/or destroy laboratory areas where biomedical research is conducted.</p> <p>Citation: (Res. 238, A-91; Appended: Res. 513, I-00; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11)</p>	
<p>H-460.975</p>	<p>Support for NIH Research Facilities</p>	<p>Our AMA urges: (1) the enactment of federal legislation which would grant to the National Institutes of Health (NIH) funding authority to expand, remodel, and renovate existing biomedical research facilities and to construct new research facilities; (2) that the authority be granted to the NIH Director and not fragmented at the categorical institute level; and (3) that institutions be required to match federal funding for this program in a systematic way.</p> <p>Citation: (BOT Rep. S, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)</p>	<p>Retain – this policy remains relevant.</p>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-JUN-21

Subject: Pharmaceutical Advertising in Electronic Health Record Systems

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2

3 At the 2019 Interim Meeting Policy D-478.961, “Pharmaceutical Advertising in Electronic Health
4 Record Systems,” was adopted by the House of Delegates (HOD). The policy directs our American
5 Medical Association (AMA) to study the prevalence and ethics of direct-to-physician advertising at
6 the point of care, including advertising in electronic health record (EHR) systems.

7

8 This report provides information about the prevalence and ethical implications of direct-to-
9 physician pharmaceutical advertising, with specific attention to advertisements and alerts in the
10 EHR.

11

12 BACKGROUND

13

14 Pharmaceutical companies have a long history of marketing to physicians in the clinical setting. In
15 recent years access to physicians has become more challenging for pharmaceutical companies—
16 nearly half of physicians restrict visits from pharmaceutical sales representatives.¹ Perhaps making
17 up for the decline in direct access, the amount of money spent on marketing and advertising to
18 physicians continues to increase. Pharmaceutical companies spent \$20.3 billion on marketing to
19 physicians in 2016 through advertisements, samples, direct payments, personal visits and gifts from
20 pharmaceutical representatives, up from \$15.6 billion 20 years earlier.² Spending on advertising in
21 digital channels such as search engines and social media platforms also continues to increase.³ The
22 EHR system has risen as a unique opportunity to directly provide information about prescription
23 drugs to prescribers, given that physicians spend more than 15 minutes per patient in the EHR.⁴
24 However, there are ethical concerns with pharmaceutical advertising in the EHR, and whether this
25 is a common practice or a sustainable business model for EHRs has yet to be explored.

26

27 AMA POLICY

28

29 The AMA supports the American pharmaceutical manufacturing industry in its efforts to develop
30 and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit
31 of the American people (Policy H-100.995, “Support of American Drug Industry”). In addition, the
32 AMA supports a ban on direct-to-consumer advertising for prescription drugs and implantable
33 medical devices (H-105.988, “Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and
34 Implantable Devices”).

35

36 *AMA Code of Medical Ethics* Opinion 9.6.7, “Direct-to-Consumer Advertisements of Prescription
37 Drugs,” states physicians should remain objective about advertised tests, drugs, treatments, and
38 devices, avoiding bias for or against advertised products. The Opinion also states physicians should

1 resist commercially-induced pressure to prescribe tests, drugs, or devices that may not be indicated.
2 Although this Opinion does not specifically address physician-directed pharmaceutical
3 advertisements, the substance and meaning are applicable. Similarly, *Code of Medical Ethics*
4 Opinion 9.6.2, “Gifts to Physicians from Industry,” asserts that gifts from industry, including
5 pharmaceutical organizations, can create conditions in which professional judgment can be put at
6 risk of bias. This Opinion suggests that to preserve the trust that is necessary in patient care,
7 physicians should decline gifts from entities that have a direct interest in physicians’ treatment
8 recommendations. AMA policy also states that no gifts should be accepted if there are strings
9 attached. For example, physicians should not accept gifts if they are given in relation to the
10 physician's prescribing practices (H-140.973, “Gifts to Physicians from Industry”).
11

12 In Policy H-175.992, “Deceptive Health Care Advertising,” the AMA encourages physicians and
13 medical societies to monitor and report to the appropriate state and federal agencies any health care
14 advertising that is false and/or deceptive in a material fact and encourages medical societies to keep
15 the Association advised as to their actions relating to medical advertising.
16

17 To mitigate adverse effects of pharmaceutical advertisements on women’s health, the AMA also
18 urges the FDA to assure that advertising of pharmaceuticals to health care professionals includes
19 specifics outlining whether testing of drugs prescribed to both sexes has included sufficient
20 numbers of women to assure safe use in this population and whether such testing has identified
21 needs to modify dosages based on sex (Policy D-105.996, “Impact of Pharmaceutical Advertising
22 on Women’s Health”).
23

24 DISCUSSION

25 *Pharmaceutical industry influence on physicians*

26
27
28 Pharmaceutical companies spend billions of dollars every year trying to influence physicians
29 through a variety of tactics. For decades, physicians have been a prime target for pharmaceutical
30 advertisers, made evident by the frequent placement of ads in medical journals. Pharmaceutical
31 companies historically have had a presence in physician offices through visits by sales
32 representatives, gifts, drug samples, sponsorship of continuing medical education, token items such
33 as notepads and pens, and more valuable incentives such as travel or dinners. This access to
34 physicians gave these companies key opportunities to influence physicians’ prescribing behaviors.
35

36 Although they still accept payments, gifts, samples, and other incentives from pharma, most
37 physicians do not believe they are affected by pharmaceutical industry interactions and believe they
38 are immune to the influence of their marketing strategies.⁵ Multiple studies, however, have found
39 associations between exposure to information provided by pharmaceutical companies and higher
40 prescribing frequency, higher costs, or lower prescribing quality.⁶ For example, exposure to
41 physician-directed advertising has been shown to be associated with less effective, lower-quality
42 prescribing decisions.⁷ This evidence suggests that some physicians, particularly those faced with
43 interactions with pharmaceutical advertising, are susceptible to influence by various types of
44 interactions with pharmaceutical companies, whether it be from gifts, payments, sponsorships, drug
45 samples, travel, or research funding. These interactions can influence physicians’ clinical decision
46 making, potentially leading to greater prescriptions of certain types of drugs.⁵
47

48 Pharmaceutical influence on physician decision-making was tested in a case study by Merck,
49 which partnered with Practice Fusion in a public health initiative to test the incorporation of EHR
50 messages alerting each provider during a patient visit when the patient might be due for a vaccine.⁸
51 The message alerts, while not considered formal advertisements, suggested specific treatment to

1 prescribers in an intervention group at the point of care, demonstrating that the alerts functioned
2 primarily to influence prescriber behavior. The test program, which included more than 20,000
3 health care providers divided into intervention and control groups, led to a 73 percent increase in
4 recorded vaccinations and the administration of more than 25,000 additional vaccines. Whether the
5 increase in vaccinations is a positive outcome is not the question to be debated in this report;
6 however, the appropriateness of the pharmaceutical company's influence in the decisions about
7 patient care should be questioned.

8 9 *Prevalence of advertising in the EHR*

10
11 One health care marketing agency that focuses in part on pharmaceutical clients described the EHR
12 as an opportunity to influence the prescribing decision with advertisements. In its report, they
13 describe banner advertisements within the administrative or consultation workflow as reminders
14 that can be targeted by physician specialty, geography, past prescribing behavior, patient
15 demographic, current therapy, or diagnosis. Their report continues, "When a [health care provider]
16 is reached in a clinical prescribing environment, the opportunity to impact behavior is greater." The
17 agency recommends prioritizing the moment within either the health records or e-prescribing
18 interface that is most meaningful based on brand objective.⁹ It is clear from these descriptions that
19 the patient-physician visit, particularly a vulnerable moment such as the discussion of medications,
20 is viewed by pharmaceutical marketers as an opportunity for financial gain.

21
22 It is estimated there are currently more than 300 EHR system vendors in the U.S.¹⁰ The vast
23 number of EHR products makes it challenging to determine the exact number of ad-supported
24 EHRs. It is known to pharma marketers that the largest EHRs do not have a business model that
25 supports advertising.⁹ Physician advisers to the AMA were consulted about the presence of
26 advertisements in the top five EHR systems, which comprise 85 percent of the market share.¹¹
27 None were aware of advertisements featured in these commonly used platforms. There may be a
28 small portion of the remaining 15 percent of EHR platforms that generate revenue through ads, but
29 currently only a handful offer partnerships with pharmaceutical companies.¹⁰

30
31 Considering the volume of information required in pharmaceutical advertisements to health care
32 professionals, as regulated by the FDA¹², pharmaceutical manufacturers and advertisers may look
33 for other means by which to promote their products at the point of care. In addition to traditional
34 banner ads, there are points of interaction between a prescriber and the EHR throughout the clinical
35 encounter that present opportunities for promotion of specific pharmaceuticals, such as clinical
36 decision support (CDS) alerts in the patient information screens. Information about specific drugs
37 may also appear during the prescribing workflow in an e-prescribing system.

38
39 Practice Fusion, a San Francisco-based company that was purchased by Allscripts in 2018, was a
40 free EHR software that provided space for pharmaceutical text and banner ads within certain
41 screens of the EHR.¹³ Practice Fusion was found to be the market share leader for solo and small
42 practices in 2015.¹⁴ In a broad search of articles about free or low-cost EHRs featuring an ad-
43 supported revenue model, Practice Fusion is repeatedly referenced as the prime example and is the
44 only EHR consistently mentioned throughout the literature.

45
46 Although many articles referenced Practice Fusion in positive light and touted it as an innovative
47 solution to the decrease in access to physicians, they all pre-dated recent legal developments
48 involving Practice Fusion. In early 2020, after months of federal investigation, Practice Fusion
49 admitted to soliciting and receiving kickbacks from a major opioid manufacturer, later discovered
50 to be Purdue Pharma, in exchange for CDS alerts that promote unnecessary opioids at the point of
51 prescribing in their EHR system.¹⁵ The Pain CDS in Practice Fusion's EHR displayed alerts more

1 than 230,000,000 times between 2016 and 2019. Health care providers who received the Pain CDS
2 alerts prescribed extended release opioids at a higher rate than those that did not,¹⁶ suggesting that
3 the alerts succeeded in influencing prescribing behavior.

4
5 This activity by Practice Fusion demonstrates how the EHR can present opportunities for
6 stakeholders to abuse the system, inappropriately influence physicians' decisions, and put patients
7 at risk. The practice of generating revenue by placing advertisements in the EHR was a key feature
8 of the system developed by Practice Fusion. Like the CDS alerts, the ads were tailored to display
9 information about specific drugs, using patient and physician data and targeting the prescriber at
10 the point of care. This ad-supported business model was abandoned by Practice Fusion in 2018
11 after its purchase by Allscripts.¹⁷

12
13 The literature search conducted in writing this report showed no evidence that ad-supported EHRs
14 have a significant presence in the EHR market or are on the rise. There was little to no mention of
15 specific ad-supported EHRs other than articles written about Practice Fusion, suggesting this single
16 company, which is now virtually defunct, had the bulk of this market captured. The conduct of
17 Practice Fusion and its extreme consequences may, for other EHR providers, put into question
18 prospective partnerships with pharmaceutical companies and slow potential growth in adoption of
19 ad-supported models.

20 21 *Advertising in other physician-facing channels*

22
23 Sometimes during patient encounters physicians require just-in-time education or review of drug
24 indications, dosage, interactions, contraindications, and pharmacology at the point of care.
25 Prescribers may consult with peers and medical experts, search for and read about drug information
26 in an authoritative medical journal, or simply search online for relevant information. In addition,
27 point-of-care medical reference applications, such as Epocrates or Medscape Mobile, provide easy
28 access to drug prescribing and safety information that physicians can use quickly during a patient
29 visit. These applications often feature advertisements for pharmaceutical products. Seventy percent
30 of Epocrates' revenue is from selling point of care pharmaceutical advertising, in the form of
31 "DocAlerts."¹⁸ Anecdotal feedback from physician users of Epocrates suggests that while they
32 appreciate using the app at no cost, they do question the appropriateness of the advertisements.^{18,19}

33 34 *Ethical implications*

35
36 Advertising at the point of care, through EHRs or other mechanisms, carries the risk of influencing
37 physician judgment inappropriately and undermining professionalism, which may ultimately
38 compromise quality of care and patient trust. While there are few data yet available about the
39 specific influence of advertisements in EHRs, studies do suggest that distributing sample
40 medications to physicians' offices, an indirect form of such advertising, does affect physicians'
41 treatment recommendations in ways that can be problematic. For example, data suggest that
42 physicians who have access to samples prefer prescribing brand name drugs over alternatives, even
43 when the branded sample is not their drug of choice or is not consistent with clinical guidelines.
44 Moreover, as one article has noted, physicians may be "less aware of when they are encountering
45 digital marketing than they are with traditional marketing."²⁰

46
47 Advertising at the point of care can undermine physicians' ethical responsibility "to provide
48 guidance about what they consider the optimal course of action for the patient based on the
49 physician's objective professional judgment."²¹ Whether a physician prescribes a medication or
50 device should rest "solely on medical considerations, patient need, and reasonable expectations of
51 effectiveness for the particular patient."²² By influencing decision making, such advertising can

1 also undermine physicians' responsibility to be prudent stewards of health care resources and to
2 "choose the course of action that requires fewer resources when alternative courses of action offer
3 similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual
4 patient but require different levels of resources."²³

5
6 There are emerging regulations at the state and federal levels that will require prescription cost
7 information to be visible in the EHR at the point of prescription. While the AMA is largely in
8 support of drug price transparency, and has clear policy encouraging EHR vendors to include
9 features that facilitate price transparency (D-155.987, "Price Transparency"), the availability of this
10 information at the point of care has the potential to influence a prescriber's decision. This potential
11 influence and its effects on prescriber patterns should be considered in future study.

12
13 While physicians have a clear ethical responsibility to ensure safe, evidence-based care, developers
14 of EHRs also have ethical responsibilities to patients. The stated goal of electronic records is to
15 facilitate seamless patient care to improve health outcomes and contribute to data collection that
16 supports necessary analysis²⁴—not to serve as a vehicle for promoting the interests of third parties.
17 Practices and health care institutions that deploy EHRs have a corresponding responsibility to
18 ensure that their record systems are directed in the first instance to serving the needs of patients.

19 20 *Implications for patient safety*

21
22 Studies of advertising in EHRs were not identified at the time of writing this report, so it is
23 premature to describe or quantify associated patient safety risks. However, physician-directed
24 pharmaceutical advertising has been commonplace in medical journals for decades, and there is an
25 abundance of research about the implications for patient safety and ethics of such ads.
26 Pharmaceutical advertisements, including those in medical journals, are regulated by the Food and
27 Drug Administration (FDA). A 2011 cross-sectional analysis of medical journals evaluated the
28 adherence of these advertisements to FDA regulations. The analysis showed few physician-directed
29 journal advertisements adhered to *all* FDA guidelines and over half of them failed to quantify
30 serious risks of the advertised drug.²⁵ Given the high risk associated with many advertised drugs,
31 and the observation that many ads do not adhere to FDA regulations or disclose known risks, any
32 propensity of pharmaceutical ads to influence prescribing—regardless of the channel—may pose
33 threats to patient safety. Thus, it is up to the physician or prescriber to base their prescribing
34 decisions on clinical evidence and sound judgment, rather than marketing tactics.

35
36 The Practice Fusion scheme is a prime example of an EHR vendor allowing commercial interests
37 to take precedence over patient safety. Although CDS tools are not advertisements in the traditional
38 sense, if the drug information in the CDS popup is presented in a way that the prescriber has little
39 choice but to view the product displayed, it is in effect an advertisement. The U.S. Department of
40 Justice highlighted the risk to patient safety in its January 2020 press release. "During the height of
41 the opioid crisis, the company took a million-dollar kickback to allow an opioid company to inject
42 itself in the sacred doctor-patient relationship so that it could peddle even more of its highly
43 addictive and dangerous opioids. The companies illegally conspired to allow the drug company to
44 have its thumb on the scale at precisely the moment a doctor was making incredibly intimate,
45 personal, and important decisions about a patient's medical care, including the need for pain
46 medication and prescription amounts."²⁶

47 48 *Implications for physician and patient data privacy*

49
50 There are important implications for the privacy of physician prescribing data and patient data
51 when it is used by advertisers to provide timely patient-specific advertisements. If an EHR vendor

1 is collecting and sharing prescribing patterns of an individual physician, or even specific patient
2 information, with the pharmaceutical company, this invites the risk of physician and/or patient data
3 misuse. Currently, there is little known about what data is being collected for this purpose, to
4 whom it is being provided, and how it is being used.

5
6 The AMA published privacy principles that define what it considers appropriate guardrails for the
7 use of patient health information outside the traditional health care setting. The principles shift the
8 responsibility for privacy from individuals to data holders, meaning that third parties who access an
9 individual's data should act as responsible stewards of that information, just as physicians promise
10 to maintain patient confidentiality.²⁷ It is AMA's position that these principles apply to any entity
11 that collects, retains, and uses patient and/or physician prescribing data for marketing and other
12 purposes.

13 14 CONCLUSION

15
16 Although some EHRs and e-prescribing programs may present opportunities for advertisers to
17 inappropriately influence patient care, they appear to have a small presence in today's EHR market.
18 And while pharmaceutical companies continue to advertise to physicians through other digital
19 channels, such as journals or medical reference applications, prescribers should continue to provide
20 care and prescribe treatments using evidence-based information and their best judgment, and
21 practices should be intentional in deploying systems that function primarily to serve patient care.
22 There is little evidence that ad-supported EHR systems are highly prevalent or gaining popularity.
23 However, where pharmaceutical advertisements *are* present at the point of care, they can present
24 significant threats to patient safety and the integrity of patient care. In addition, it is evident that
25 despite prescribers' best intentions there are instances in which decision-making can be influenced
26 by external factors such as CDS alerts or advertisements. Considering the information presented in
27 this report, it is recommended that AMA establish policy opposing the practice of pharmaceutical
28 advertising in electronic systems used at the point of care and continue to monitor the practice in
29 the future.

30 31 RECOMMENDATIONS

32
33 The Board of Trustees recommends that Policy D-478.961 be amended as follows and the
34 remainder of the report be filed:

35
36 Our AMA: (1) opposes direct-to-prescriber pharmaceutical and promotional content in electronic
37 health records (EHR); and (2) opposes direct-to-prescriber pharmaceutical and promotional content
38 in medical reference and e-prescribing software, unless such content complies with all provisions
39 in Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices
40 (H-105.988); and (3) encourages the federal government to study of the effects of direct-to-
41 physicianprescriber advertising at the point of care, including advertising in Electronic Health
42 Record Systems (EHRs), on physician prescribing, patient safety, data privacy, health care costs,
43 and EHR access for smallphysician practices; ~~and (2) will study the prevalence and ethics of~~
44 ~~direct-to-physician advertising at the point of care, including advertising in EHRs.~~

Fiscal note: Less than \$500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-JUN-21

Subject: Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee B

1 The COVID-19 pandemic has had devastating health consequences and caused widespread, serious
2 disruption in the U.S. and worldwide. As of May 2021, there have been more than 32 million cases
3 of COVID-19 in the U.S. and 576,238 COVID-19-related deaths. In 2020, the estimated age-
4 adjusted death rate increased 15.9 percent compared with 2019 and COVID-19 was the underlying
5 or a contributing cause of 377,883 deaths; COVID-19 death rates were highest among males, older
6 adults, and American Indian/Alaska Native, Hispanic, and Black persons.¹ According to the
7 National Center for Health Statistics, COVID-19 was the third leading underlying cause of death in
8 2020, replacing suicide as one of the leading causes of death.²

9
10 The use of vaccine credentialing and/or mandatory vaccination has been urged to speed the return
11 to “normal.” Although existing AMA policy provides guidance on routine vaccinations, COVID-19
12 and COVID-19 vaccines present unique and challenging circumstances for which additional policy
13 is needed.

14
15 DIGITAL VACCINATION CREDENTIAL SERVICES (DVCS)

16
17 With more people getting vaccinated and a strong desire from the public to return to “normal” life,
18 many companies are developing digital vaccine credential services (DVCS), often referred to by
19 the misnomer “vaccine passports.”¹ The term DVCS collectively refers to a digital vaccine
20 credential issuer, a digital vaccine credential app/platform, or a digital vaccine credential requestor.
21 A vaccine credential issuer refers to those who administer vaccines to individuals (e.g., physician
22 offices, hospitals). A digital vaccine credential app/platform is the technology an individual would
23 use to obtain a digital credential stating they have been vaccinated (i.e., a digital form of paper
24 vaccination record). A digital vaccine credential requestor is any entity that seeks to view and
25 possibly utilize the digital credential for some purpose (e.g., a sports venue that will only admit
26 individuals who possess digital vaccine credentials).

27
28 Requiring proof of vaccination is not a novel concept in this country; for example, most
29 jurisdictions require students to provide proof of vaccination prior to attending not only elementary
30 and secondary schools, but also higher education and childcare facilities. Additionally,
31 international travel often requires proof of vaccination against certain communicable diseases.

¹ AMA prefers the term “vaccine credential” to the frequently used “vaccine passport.” The latter is misleading and its purposes can be misunderstood. Passports are legal documents issued by nations to control entry and exit from a country and may also be used as legal identification. Vaccine credentials, in contrast, are medical documents that document an individual’s vaccination status. See Benjamin GC, *Vaccine Passports Are a Premature Solution to a Challenging Problem* (April 19, 2021) available at <https://leaps.org/vaccine-passports-are-a-premature-solution-to-a-challenging-problem/particle-1>.

1 Clearly these are specific use cases that do not apply to the country’s entire population. DVCS,
2 however, may be utilized by hundreds of millions of people across society depending on the scope
3 of digital vaccine credential requestors planning to require digital vaccine credentials for entry into
4 or participation in certain events, facilities, and venues, helping to reduce transmission and at the
5 same time allowing participants to signal that they mutually share the protection of each having
6 been vaccinated. Some envision DVCS potentially serving as a “critical driver for restoring
7 baseline population health and promoting safe return to social, commercial, and leisure activities.”³
8 There are already nearly 20 DVCS in development, and multiple states and other jurisdictions have
9 developed their own DVCS.⁴

10
11 DVCS may provide multiple benefits that paper records do not. For example, paper records can be
12 lost. They may also require individuals to make additional trips to physician offices or pharmacies
13 to pick up copies of their vaccination records, which can be burdensome to both the patient and
14 practice. Nor is it clear how individuals who received vaccine at mass vaccination events can
15 obtain records after the event. Moreover, patients receive vaccinations at different stages
16 throughout their lives. Additionally, paper vaccination records can be stolen or fraudulently
17 produced—something already happening with COVID-19 vaccination cards.⁵ Accordingly, DVCS
18 potentially serve as a reliable, convenient, and accurate mechanism by which one can demonstrate
19 and verify their vaccination status. The DVCS seek to authentic vaccination status by providing a
20 direct, electronic way to trace back where the information came from (a concept in health
21 information technology known as provenance).

22
23 The use of DVCS is not without potential pitfalls, however. Some challenges are practical, such as
24 ensuring that DVCS can successfully access source data stored in different formats, whether
25 hardcopy or electronic, among the many entities that are providing COVID-19 vaccination.
26 Significant questions remain around the ethics of DVCS usage, support, and mandates.⁶ Some
27 states have or are attempting to ban the use of DVCS outright, reinforcing political divisions over
28 COVID-19 vaccination.⁷ Even though the Biden administration has stated that it will not develop a
29 federal DVCS, the AMA believes there is still an important role for the federal government to play
30 in establishing, publicizing, and enforcing guidelines to which all DVCS must adhere.⁸

31
32 First, the use of DVCS must not outpace vaccine availability. Although supplies are rapidly
33 increasing, vaccines are not yet universally accessible, particularly to individuals in historically
34 marginalized and minoritized communities. Until all Americans are easily able to access vaccines
35 and trusted DVCS, we must guard against programs that appear to confer special social privilege
36 based on one’s COVID-19 vaccination status. Additionally, the pandemic has demonstrated our
37 country’s stark disparities in access to technology, inequitable technology innovation and design
38 priorities, and digital literacy. A DVCS must ensure that individuals can access their credentials in
39 hard copy. Relatedly, both access to DVCS and DVCS functionality, content, and user interface
40 must be designed with and for historically minoritized and marginalized communities. DVCS must
41 address issues of culture, language, digital literacy, and access to broadband services to ensure that
42 the tools are usable by all individuals and do not de facto discriminate.

43
44 Second, most of the digital vaccine credential apps/platforms individuals may use to obtain their
45 digital vaccine credentials will not be subject to any sort of federal privacy protections (including
46 the health sector specific privacy law, the Health Insurance Portability and Accountability Act of
47 1996 [HIPAA]). The AMA has advocated very strongly in recent years that the use of apps outside
48 of HIPAA—despite their potential to improve individual access to one’s own health information—
49 pose a significant threat to the privacy of such information.⁹ Failure to address the lack of privacy
50 requirements in apps can also stymie the uptake of innovative technologies that could potentially
51 improve public health. Such failure, along with concern about surveillance, lack of coordination,

1 and distrust of technology companies contributed to sluggish adoption of digital contact-tracing
2 apps early in the pandemic.

3
4 Vaccine credentialing apps are likely to face similar concerns regarding privacy, surveillance, and
5 apprehension. Specifically, individuals subject to disproportionate rates of incarceration and
6 heightened surveillance based on immigration status or race; those with stigmatized health
7 conditions such as substance use disorder, HIV/AIDS, and other sexually transmitted infections;
8 LGBTQ individuals; unhoused people; and individuals with disabilities may be wary of DVCS due
9 to the possibility that third parties will share their data with employers, insurers, landlords, the
10 police, or other government agencies. Accordingly, the AMA recommended that the federal
11 government develop guidelines around data governance, including (but not limited to) utilization of
12 classic data privacy principles such as data minimization (i.e., only collecting the minimum amount
13 of information necessary to function as a credential), data sunset rules (i.e., discarding data once it
14 is no longer needed), and data sharing defaults that require users to opt-in to broader, automatic
15 data sharing (as opposed to forcing users to take additional steps to opt-out of such sharing).

16
17 Lastly, DVCS policy is likely to shift as vaccine availability increases and scientific evidence of
18 effectiveness or limitations grows.¹⁰ DVCS will need updates to accommodate these changing
19 requirements. No one organization, app marketplace, or industry will be able to track, monitor, and
20 provide individuals meaningful information on credentialing services, including data use policies
21 or app adherence to development principles. Individuals should have access to a single source of
22 truth where they can clearly understand features, functions, and the policies by which apps abide.
23 Accordingly, the AMA has recommended that DVCS register with the federal government after
24 meeting the above-described federal guidelines and be included on a public-facing list of all
25 registered DVCS along with clear and understandable information about each DVCS.

26 27 VACCINE MANDATES

28
29 As supplies of COVID-19 vaccines become available to meet demand vaccine hesitancy is high,
30 leading to doubt that the U.S. will be able to achieve “herd immunity,”¹¹ there have been calls for
31 mandating vaccination, especially for frontline health care workers, first responders, or others
32 considered essential workers, and students.¹² Mandates are legal and enforceable for interventions
33 that have been licensed by the U.S. Food and Drug Administration (FDA), but there are questions
34 about whether that is also the case for interventions released under an Emergency Use
35 Authorization (EUA), as COVID vaccines were initially.^{13,14} However, Pfizer/BioNTech recently
36 submitted a Biologics License Application (BLA) for their COVID-19 vaccine, asking for
37 expedited review and it is expected that FDA will soon grant a BLA.¹⁵

38
39 Vaccine mandates serve a fundamentally different purpose from DVCS: where DVCS offer
40 individuals opportunity to resume at least a semblance of “normal” activities in the absence of herd
41 immunity,¹⁶ mandates are promoted precisely as a means to achieve that immunity. The primary
42 intent of a mandate is to protect the health of the community, with benefit to the individual
43 secondary. Like DVCS, vaccine mandates raise concerns about equity, but given the different goal
44 to which they are directed, they do so in a somewhat different way. DVCS ease restrictions on
45 individuals but may unfairly exclude those who would choose to be vaccinated but cannot access
46 vaccine. Mandates intentionally impose restrictions by obviating personal choice and requiring
47 everyone to be vaccinated, with only limited exceptions, when voluntary uptake does not reach
48 levels that will achieve the public health goal of herd immunity. Importantly, privacy is less a
49 concern with respect to vaccine mandates than are issues of autonomy.

1 Historically, public health restrictions have been imposed on individual autonomy in the interest of
2 protecting the health of the community, and the legality of state-imposed vaccine mandates is well-
3 established. Since the landmark case *Jacobson v. Massachusetts* in 1905, the law has generally
4 favored states' ability to exercise the police power to compel vaccination "as the safety of the
5 general public may demand" even at the expense of individual liberty.¹⁷
6

7 All states currently employ vaccine mandates in some form, most in alignment with the
8 recommendations of the Centers for Disease Control and Prevention's (CDC's) Advisory
9 Committee on Immunization Practices (ACIP). As noted previously, all states require students to
10 provide proof of vaccination for specified vaccines before they are permitted to attend school.
11 Many require staff of health care institutions, public and private, to be vaccinated for a range of
12 infectious diseases, including seasonal influenza, to protect patients, staff, and the broader
13 community. All states permit medical exemptions for individuals who have contraindications for
14 vaccinations. Some allow parents or guardians to opt out of vaccination requirements if they object
15 on the basis of religious beliefs (44 states), or personal, moral, or other beliefs (15).
16

17 Mandates that allow non-medical exemptions are problematic. AMA policy supports eliminating
18 such exemptions, and further recommends that states have processes in place to determine which
19 vaccines will be mandatory for admission to school and other identified public venues and that
20 such mandates be based on ACIP recommendations.¹⁸ Policy also recognizes that health care
21 workers have strong obligations to accept vaccination voluntarily, particularly for vaccine
22 preventable diseases that are or may become epidemic or pandemic that pose significant medical
23 risk or threaten the availability of the health care workforce.¹⁹ AMA policy further encourages use
24 of mechanisms to encourage vaccine uptake, such as providing vaccination at no cost for
25 employees, up to and including making vaccination a condition of employment.²⁰
26

27 Research has demonstrated that vaccine mandates, and the elimination of non-medical exemptions
28 to those mandates, are effective at increasing immunization rates. COVID-19 vaccination is a
29 critical prevention measure to help end the COVID-19 pandemic. The three COVID-19 vaccines
30 currently authorized by the FDA for emergency use and recommended for use in the U.S.
31 population by the CDC as recommended by the ACIP have been shown to be effective against
32 SARS-CoV-2 infections, including the prevention of severe disease and death. According to the
33 CDC, as of May 7, 2021 about 45 percent of the total U.S. population have received one dose of
34 vaccine and about 33 percent have been fully vaccinated.²¹ However, the number of administered
35 vaccine doses is decreasing. There are currently five SARS-CoV-2 variants of concern circulating
36 for which there is evidence of an increase in transmissibility, more severe disease, significant
37 reduction in neutralization by antibodies generated during previous infection or vaccination,
38 reduced effectiveness of treatments or vaccines, or diagnostic detection failures.²²
39

40 Whether it is ethically acceptable for public or private entities to mandate vaccination as a
41 condition of access to employment; education; or other activities, goods, or services requires
42 thoughtful balancing of multiple considerations, including how readily the disease in question is
43 transmitted; what medical risk the disease represents for individuals and the community at large;
44 how risks of exposure are distributed across the population; the safety and efficacy of available
45 vaccine(s); the effectiveness and appropriateness of vaccination relative to other strategies for
46 preventing disease transmission; the medical value or possible contraindication of vaccination for
47 the individual; and the prevalence of the disease. The more readily transmissible a disease and the
48 greater the risk to those with whom an infected individual comes in contact relative to risks of
49 vaccination, the stronger the argument for mandatory vaccination. Given the high rate of
50 asymptomatic transmission in COVID-19, vaccinating the greatest number of individuals possible
51 is critical. Yet despite their effectiveness as public health tools, vaccine mandates are a blunt

1 instrument and may carry the risk of further eroding trust and ultimately undermining public health
2 goals.

3
4 Mandates are inherently coercive and have the potential to impose burdens unequally across
5 communities. For example, employer mandates that put livelihoods at risk may be especially
6 onerous in communities where opportunities for employment are limited. The COVID-19
7 pandemic has already had devastating effect among marginalized and minoritized communities for
8 individuals who have had no choice but to accept the risk of disease to preserve their livelihoods.
9 Moreover, mandating vaccination may further alienate individuals who are mistrustful of authority,
10 of vaccines generally, or of COVID-19 vaccines specifically even while it serves important public
11 health goals. They should therefore be implemented with these considerations in mind and efforts
12 made to minimize the potential to exacerbate existing inequities and adversely affect marginalized
13 and minoritized communities to the extent feasible.

14
15 If successful in increasing vaccine uptake, efforts to promote voluntary vaccination would better
16 respect recipients' autonomy and minimize the potential to impose disproportionate burdens on
17 marginalized and minoritized communities. For example, Maryland is now offering \$100 to state
18 employees who are fully vaccinated for COVID-19, while West Virginia is offering \$100 savings
19 bonds to young residents to get vaccinated and Connecticut is partnering with a restaurant trade
20 group to offer free drinks at certain restaurants for residents who have been vaccinated.²³ However,
21 data are not yet available to indicate whether such efforts might be effective in persuading enough
22 individuals to seek vaccination voluntarily that the U.S. could avoid the need to mandate
23 vaccination to control the spread of COVID-19.

24
25 With respect to health care professionals, guidance in the AMA Code of Medical Ethics provides
26 that physicians have a professional ethical responsibility to be vaccinated, absent medical
27 contraindications, and enjoins physicians who are not vaccinated for whatever reason to voluntarily
28 take steps to protect patients, fellow staff, and the public, including refraining from direct patient
29 contact.²⁴ Guidance further delineates the responsibilities of health care institutions to protect
30 patients and staff from epidemic or pandemic disease, such as providing and requiring use of
31 appropriate protective equipment and making vaccination readily available. Guidance recognizes
32 that this responsibility may extend to requiring staff to be vaccinated (absent medical
33 contraindication) when a safe, effective vaccine is available.

34 35 RECOMMENDATION

36
37 In light of the foregoing, the Board of Trustees recommends that the following be adopted and the
38 remainder of this report be filed:

39
40 COVID-19 and COVID-19 vaccines raise unique challenges. To meet these challenges, our
41 AMA:

- 42
43 1. Encourages the development of clear, strong, universal, and enforceable federal guidelines
44 for the design and deployment of digital vaccination credentialing services (DVCS), and
45 that before decisions are taken to implement use of vaccine credentials
 - 46 a. vaccine is widely accessible;
 - 47 b. equity-centered privacy protections are in place to safeguard data collected from
48 individuals;
 - 49 c. provisions are in place to ensure that vaccine credentials do not exacerbate inequities;
50 and

- 1 d. credentials address the situation of individuals for whom vaccine is medically
2 contraindicated (New HOD Policy)
3
- 4 2. Recommends that decisions to mandate COVID-19 vaccination be made only:
 - 5 a. After a vaccine has received full approval from the U.S. Food and Drug Administration
6 through a Biological Licenses Application;
 - 7 b. In keeping with recommendations of the Advisory Committee on Immunization
8 Practices for use in the population subject to the mandate as approved by the Director
9 of the Centers for Disease Control and Prevention;
 - 10 c. When individuals subject to the mandate have been given meaningful opportunity to
11 voluntarily accept vaccination; and
 - 12 d. Implementation of the mandate minimizes the potential to exacerbate inequities or
13 adversely affect already marginalized or minoritized populations. (New HOD Policy)
- 14
- 15 3. Encourages the use of well-designed education and outreach efforts to promote vaccination
16 to protect both public health and public trust. (New HOD Policy)

Fiscal Note: Less than \$500.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(JUN-21)

Introduced by: Maryland

Subject: Ensuring Continued Enhanced Access to Healthcare via Telemedicine and
Telephonic Communication

Referred to: Reference Committee B

- 1 Whereas, Across the U.S., states passed telemedicine legislation in 2020 (pre-pandemic) that
2 allows providers to use telehealth, including asynchronous technology, to establish the
3 physician-patient relationship; and
4
5 Whereas, The ability to access health care via telemedicine prior to the pandemic was available,
6 but not widely used; and
7
8 Whereas, Payments to physicians for telemedicine vary by carrier and were significantly less
9 than in-person visits prior to COVID-19; and
10
11 Whereas, The onset and severity of COVID-19 caused a rapid implementation of telemedicine
12 by physicians of many specialties, and patients rapidly embraced the technology as often the
13 only means to access non-emergent medical care; and
14
15 Whereas, Through directives of the federal and state governments, payors waived co-pays and
16 deductibles and increased payment for telemedicine and telephonic services equal to in-person
17 visits during COVID-19 which reduced barriers for patients to access medical care; and
18
19 Whereas, The federal government and states took action to allow physicians and other health
20 care clinicians to use non-HIPAA compliant platforms if necessary to enhance patients' use of
21 technology to access health care; therefore be it
22
23 RESOLVED, That our American Medical Association address the importance of at least a
24 365-day waiting period after the COVID-19 public health crisis is over before commencement of
25 audits aimed at discovering the use of non-HIPAA compliant modes and platforms of
26 telemedicine by physicians. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 04/07/21

AUTHOR'S STATEMENT OF PRIORITY

Due to urgent need, many physician practices implemented non-HIPAA-compliant telehealth platforms during the initial stages of the pandemic state of emergency in an attempt to ensure continuation of services and quality care for their patients. This resolution asks for the AMA to advocate for a 365-day waiting period after the COVID-19 pandemic crisis ends before commencement of HIPAA audits relating to telehealth usage. It is important that the AMA establish this policy platform before states of emergency expire and pandemic-related administrative flexibilities are terminated.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(JUN-21)

Introduced by: New York
Subject: Prohibit Ghost Guns
Referred to: Reference Committee B

1 Whereas, Homemade, difficult to trace firearms are increasingly turning up at crime scenes; and
2
3 Whereas, The most important part of a gun is the lower receiver - the 'chassis' of the weapon,
4 the part housing vital components such as the hammer and trigger; and
5
6 Whereas, Under federal law, the lower receiver is considered a firearm - while other gun
7 components do not require a background check for purchase; and
8
9 Whereas, Dozens of companies sell what are known as "80%" lower receivers - ones that are
10 80% finished, lack a serial number and can be used to make a homemade gun; and
11
12 Whereas, The Gun Control Act (1968) and the Brady Gun Violence Prevention Act (1993) allow
13 for homemade weapons; and
14
15 Whereas, Ghost guns don't have any unique markings and therefore present black holes to
16 police investigators; and
17
18 Whereas, Ghost guns provide an easy avenue for people banned from owning guns to obtain
19 them; and
20
21 Whereas, According to the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) 30% of
22 all weapons recovered by the bureau in California were homemade; and
23
24 Whereas, These weapons have been connected with mass shootings, police shootouts and
25 arms trafficking; therefore be it
26
27 RESOLVED, That our American Medical Association support state and federal legislation and
28 regulation that would subject homemade weapons to the same regulations and licensing
29 requirements as traditional weapons. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 04/24/21

AUTHORS STATEMENT OF PRIORITY

This resolution expands the current AMA policy on gun safety. Additionally, it dovetails with the recently stated objectives of the US President and Senate Majority Leader. The best solution is a national (federal) one and AMA should be a part of that as a national organization. AMA must expand its policy to include this.

RELEVANT AMA POLICY

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

- (A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
- (B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
- (C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
- (D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
- (E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
- (F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
- (G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to:

(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;

(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;

(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);

(d) the imposition of significant licensing fees for firearms dealers;

(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and

(f) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

(4) Oppose concealed carry reciprocity federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(JUN-21)

Introduced by: New York

Subject: Ban the Gay/Trans (LGBTQ+) Panic Defense

Referred to: Reference Committee B

1 Whereas, The gay/trans panic (to be more inclusive will use “LGBTQ+ panic”) defense strategy
2 is a legal strategy that uses a victim’s sexual orientation or gender identity/expression as an
3 excuse for a defendant’s violent reaction, seeking to legitimize and even to excuse violent and
4 lethal behavior (1); and

5
6 Whereas, The LGBTQ+ panic defense strategy gives defendants three options of defense: 1)
7 insanity or diminished capacity, 2) provocation, 3) self-defense (3); and

8
9 Whereas, To claim:

10
11 - insanity, defendants claim that the sexual orientation or gender of the victim is enough to
12 induce insanity (1);

13
14 - provocation, defendants claim “victim’s proposition, sometimes termed a “non-violent sexual
15 advance” was sufficiently “provocative” to induce the defendant to kill the victim”(1);

16
17 - self-defense, “defendants claim they believed that the victim, because of their sexual
18 orientation or gender identity/expression, was about to cause the defendant serious bodily
19 harm (3)”; and

20
21 Whereas, Studies have shown that jurors with higher homonegativity and religious
22 fundamentalism ratings assigned higher victim blame, lower defendant responsibility, and more
23 lenient verdicts in the “LGBTQ+ panic” conditions (5,6,7); and

24
25 Whereas, “Gay panic disorder” was removed from the DSM in 1973 because the APA
26 recognized that no such condition exists; and

27
28 Whereas, Many murder sentences have been reduced or defendants have been acquitted using
29 the LGBTQ+ panic defense strategy such as in the Matthew Shepard case, to successfully
30 mitigate a charge from murder to criminally negligent manslaughter as recently as 2018 (1); and

31
32 Whereas, The LGBTQ community makes up 3.5% of the US population yet, sexual orientation
33 is the motivator of 17% of hate crime attacks with one in four transgender people becoming the
34 victim of a hate crime in their lifetime (4, 5); and

35
36 Whereas, the LGBTQ+ panic defense has only been banned in 11 states as of February 2021,
37 with legislation having been introduced in 12 more states (1, 2); and

1 Whereas, NY State passed a law in June 2019 banning the gay/trans (LGBTQ+) panic defense,
2 and MSSNY should have policy to support this law and prevent the risk for a setback in
3 protections for LGBTQ+ people; and
4

5 Whereas, At least 44 Transgender or Gender Non-Conforming persons have been killed in the
6 US during the year 2020, the highest total since HRC started tracking in 2013 (9); and
7

8 Whereas, There is not a race panic defense for a reason, and similar reasoning must disallow a
9 gay/trans (LGBTQ+) panic defense; therefore be it
10

11 RESOLVED, That our American Medical Association seek a federal law banning the use of the
12 so-called “gay/trans (LGBTQ+) panic” defense in homicide, manslaughter, physical or sexual
13 assault cases (Directive to Take Action); and be it further
14

15 RESOLVED, That our AMA publish an issue brief and talking points on the topic of so called
16 “gay/trans (LGBTQ+) panic” defense, that can be used by our AMA in seeking federal
17 legislation, and can be used and adapted by state and specialty medical societies, other allies,
18 and stakeholders as model legislation when seeking state legislation to ban the use of so-called
19 “gay/trans (LGBTQ+) panic” defense to mitigate personal responsibility for violent crimes such
20 as assault, rape, manslaughter, or homicide. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY:

Transgender people, our patients, specifically transgender women of color, are at an extremely high risk of dying by homicide. Last year a record number of deaths were recorded in the US (46- an underestimate given the under reporting of transgender identity). By mid-April, there are 15 known homicides of transgender people as reported by HRC. If this pace continues for 2021, another record will be broken on pace for over 50 homicides this year. AMA must act now to protect transgender people, and to send a clear message to all of our transgender patients and our LGBTQ+ patients, that we see them, value them, support them, and fight for them. This resolution must be heard at the AMA in June or another year of murders will occur before model legislation is shared, to provide justice for transgender people.

RELEVANT AMA POLICY

Preventing Anti-Transgender Violence H-65.957

Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an

individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.

Citation: Res. 008, A-19

Access to Basic Human Services for Transgender Individuals H-65.964

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

Citation: Res. 010, A-17

Support of Human Rights and Freedom H-65.965

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

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

References:

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5. Coston, Liz. "Understanding and Handling Hate Crimes against Gay, Bisexual, and Transgender People." Scholars Strategy Network, 9 Nov. 2018, scholars.org/brief/understanding-and-handling-hate-crimes-against-gay-bisexual-and-transgender-people.
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9. An Epidemic of Violence: Fatal Violence Against Transgender and Gender Nonconforming People in the United States in 2020. Human Rights Campaign, 2021. Downloaded 18 February 2021 at: <https://hrc-prod-requests.s3-us-west-2.amazonaws.com/FatalViolence-2020Report-Final.pdf?mtime=20201119101455&focal=none>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(JUN-21)

Introduced by: New York
Subject: Insurers and Vertical Integration
Referred to: Reference Committee B

1 Whereas, Insurers already enjoy significant marketplace advantages, such as keeping
2 healthcare data opaque from other stakeholders, marketplace consolidation, and monopsony
3 power; and
4
5 Whereas, These advantages have not resulted in cost savings (or even stability) for
6 consumers--in fact cost increases born by consumers have been outsized and correlated with
7 consolidation; and
8
9 Whereas, Insurers have increasingly been pursuing mergers--in the name of promoting
10 efficiency; and
11
12 Whereas, These "efficiencies" rarely, if ever, benefit the consumer; and
13
14 Whereas, These combined entities (especially vertical ones) are more competitive among their
15 competitors than the uncombined ones (accelerating further consolidation); and
16
17 Whereas, The combined entities are also positioned (due to their superior access to capital) to
18 unfairly disrupt entities at other points in the supply chain such as medical practices, community
19 pharmacies, and safety net hospitals; therefore be it
20
21 RESOLVED, That our American Medical Association seek legislation and regulation to prevent
22 health payers (except non-profit HMO's) from owning or operating other entities in the health
23 care supply chain. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

As a matter of protecting public health and reducing health payor interference in patient care delivery, it is critical that AMA continue to actively work to prevent large entities from creating these monopolies. While the AMA has taken important steps in recent years to challenge these mergers and acquisitions, existing AMA policy is four years old. The efforts on the part of health payers to absorb practices, pharmacy benefit managers, medical equipment suppliers etc. continues and will create a health care market without any competition. This will not be good for our patients nor for physicians. These entities should be controlled by nothing more than the competitive free market system. Allowing health insurers to control more and more elements of the health care supply chain will result in even greater interference in the physician-patient relationship and decrease access to care for our patients. AMA is strongly urged to take immediate action to update its policy on this subject.

RELEVANT AMA POLICY

Health Insurance Company Purchase by Pharmacy Chains D-160.920

Our AMA will: (1) continue to analyze and identify the ramifications of the proposed CVS/Aetna or other similar merger in health insurance, pharmacy benefit manager (PBM), and retail pharmacy markets and what effects that these ramifications may have on physician practices and on patient care; (2) continue to convene and activate its AMA-state medical association and national medical specialty society coalition to coordinate CVS/Aetna-related advocacy activity; (3) communicate our AMAs concerns via written statements and testimony (if applicable) to the U.S. Department of Justice (DOJ), state attorneys general and departments of insurance; (4) work to secure state level hearings on the merger; and (5) identify and work with national antitrust and other legal and industry experts and allies.

Citation: BOT Action in response to referred for decision Res. 234, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(JUN-21)

Introduced by: South Carolina, Alabama, Florida, Mississippi, New Jersey,
Oklahoma, West Virginia, Arkansas, North Carolina

Subject: Protection of Peer-Review Process

Referred to: Reference Committee B

1 Whereas, Peer review is the task of self-monitoring and maintaining the administration of patient
2 safety and quality of care, consistent with optimal standards of practice. It is the mechanism by
3 which the medical profession fulfills its obligation to ensure that its members are able to provide
4 safe and effective care; and

5
6 Whereas, It is the mechanism by which the medical profession fulfills its obligation to ensure
7 that its members are able to provide safe and effective care; and

8
9 Whereas, It is a mechanism for assuring the quality, safety, and appropriateness of hospital
10 services. The duties of peer review are: addressing the standard of care, preventing patient
11 harm, evaluating patient safety and quality of care, and ensuring that the design of systems or
12 settings of care support safety and high quality care; and

13
14 Whereas, Proceedings include all of the activities and information and records of a peer review
15 committee. Proceedings are not subject to discovery and no person who was in attendance at a
16 meeting of a peer review organization shall be permitted or required to testify in any such civil
17 action as to any evidence or other matters produced or presented during the proceedings of
18 such organization or as to any findings, recommendations, evaluations, opinions, or other
19 actions of such organization or any members thereof; and

20
21 Whereas, The proceedings, records, findings, and recommendations of a peer review
22 organization are not subject to discovery. Information gathered by a committee is protected.
23 Purely factual information, such as the time and dates of meetings and identities of any peer
24 review committee attendees is protected. Peer review information otherwise discoverable from
25 "original sources" cannot be obtained from the peer review committee itself; and

26
27 Whereas, A U.S. Senate Oversight Committee in investigating UNOS (United Network for
28 Organ Sharing) has subpoenaed "all relevant materials to include peer-review related
29 materials"; therefore be it

30
31 RESOLVED, That our American Medical Association use its full ability and influence to oppose
32 any new attempt(s) to make Peer Review proceedings, regardless of the venue, discoverable,
33 even if by the US Congress or other US Governmental entity. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 04/28/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be considered by our AMA House of Delegates as an URGENT resolution because of the on-going attempts by Oversight Committees of the US Congress to obtain peer-reviewed data which would include information by transplant surgeons as well as other physicians involved in the life-saving task of organ transplantation. There can be no guarantee that protected information would not be released in violation of the spirit of peer-reviewed procedures.

RELEVANT AMA POLICY

Legal Protections for Peer Review H-375.962

Definition and Purpose of Peer Review

Peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care. The responsibility assigned to and scope of peer review is the practice of medicine; ie, professional services administered by a physician and the portion of care under a physician's direction. Therefore, elements of medical care, which describe the knowledge, skills, attitudes, and educational experiences of physicians and provide the foundation of physician activities, are subject to peer review and its protections. Those elements include, but are not limited to the following: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. Activities that comprise medical care are subject to the scope and rigor of peer review and entitled to the protections and privileges afforded by peer review law.

Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care. Accountability to patients and their care, to the medical profession and colleagues, and to the institution granting privileges is inherent to the peer review process.

Composition of the Peer Review Committee

Peer review is conducted in good faith by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that is convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.

Definitions

Good Faith Peer Review. Peer review conducted with honest intentions that assess appropriateness and medical necessity to assure safe, high-quality medical care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process to achieve a desired result other than improved patient care), or misuse of the peer review process, or peer review that is politically motivated, manipulated to achieve economic gains, or due to personal vendetta is not considered a good faith peer review.

Medical Peer Review Organizations. Any panel, committee, or organization that is composed of physicians or formed from a medical staff or formed by statute, such as physician wellness peer review boards, which engages in or utilizes peer reviews concerning the care and treatment of patients for the purposes of self-monitoring and maintaining the administration of patient safety and quality of care consistent with optimal standards of practice is a medical peer review organization. The responsibility of a medical peer review organization is to ensure: (1) that all physicians consistently maintain optimal standards of competency to practice medicine; and (2) the quality, safety, and appropriateness of patient care services. The medical peer review committee's obligations include review of allegations of infirmity (e.g., fitness to practice medicine), negligent treatment, and intentional misconduct. Peer review protections and privilege should extend to investigation and subsequent correction of negligent treatment

and intentional misconduct.

Proceedings. Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of a peer review organization, nor should any person who testifies before a peer review organization or who is a member of a peer review organization be prevented from testifying as to matters within his/her knowledge; but such witness cannot be asked about his/her testimony before a peer review organization or about opinions formed by him/her as a result of the peer review organization hearings.

Peer Review Activity. Peer review activity means the procedure by which peer review committees or quality assessment and assurance committees monitor, evaluate, and recommend actions to improve and ensure the delivery and quality of services within the committees' respective facilities, agencies, and professions, including recommendations, consideration of recommendations, actions with regard to recommendations, and implementation of actions.

Peer Review Records. Peer review records mean all complaint files, investigation files, reports, and other investigative information relating to the monitoring, evaluation, and recommendation of actions to improve the delivery and quality of health care services, licensee discipline, or professional competence in the possession of a peer review committee or an employee of a peer review committee.

Privilege. The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff.

Confidentiality. Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.

Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in good faith peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities.

Citation: BOT Rep. 10, A-09; Reaffirmed: BOT Rep. 13, I-11; Modified: BOT Rep. 05, I-17

Reviewer Immunity D-375.997

Our AMA will: (1) recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions; (2) monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process; and (3) continue to work to provide peer review protection under federal law.

Citation: (BOT Rep.8, I-01; Reaffirmation A-05; Modified: CCB/CLRPD Rep. 2, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(JUN-21)

Introduced by: American Academy of Pediatrics

Subject: Redefining the Definition of Harm

Referred to: Reference Committee B

1 Whereas, Respecting and maintaining patients' confidentiality is imperative for the health and
2 well-being of adolescent patients, the current HIPAA definitions only allow a physician to
3 withhold the release of information in cases of anticipated *physical* harm to the patient or
4 another individual; and

5
6 Whereas, The release of requested PHI on patients to their proxies and/or representatives in
7 sensitive areas like reproductive health, mental health or substance use may not result in
8 physical harm to the adolescent, it could result in severe mental anguish or emotional distress
9 as they deal with the reaction from their family members and breach of privacy by their provider;
10 and

11
12 Whereas, Pediatric patients, including adolescents, are unique in that their legal rights to
13 provide consent and receive confidential care are limited, pediatricians and other clinicians who
14 provide health care for children and adolescents, and who are stewards of EHI for those
15 patients, should be granted discretion and latitude in sharing EHI when they are concerned
16 about the impact/consequences for the child; and

17
18 Whereas, Adolescents by their nature often act impulsively, release of sensitive PHI that they do
19 not want shared with others could result in mental or emotional harm that could lead to physical
20 self-harm or an impulse to harm others; and

21
22 Whereas, Under current regulations (both HIPAA and the 21st Century Cures Act Interoperability
23 Final Rule) physicians must release health information even when, in their professional
24 judgement, they believe that doing so could emotionally or psychologically harm their patient;
25 therefore be it

26
27 RESOLVED, That our American Medical Association advocate to the Office of Civil Rights to
28 revise the definition of harm to include mental and emotional distress. Such a revision would
29 allow additional flexibility for clinicians under the Preventing Harm Exception, based on their
30 professional judgement, to withhold sensitive information they believe could cause physical,
31 mental or emotional harm to the patient (Directive to Take Action); and be it further

32
33 RESOLVED, That our AMA advocate that the Office of Civil Rights assemble a commission of
34 medical professionals to help the office review the definition of harm and provide scientific
35 evidence demonstrating that mental and emotional health is intertwined with physical health.
36 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/07/21

AUTHORS STATEMENT OF PRIORITY

The Federal Office of the National Coordinator for Health Information Technology allows physicians to block the release of medical information to patients and families that is “likely to endanger the life or physical safety of the individual or other person”, it currently excludes psychological or emotional harm, this resolution asks that that those harms be added as reasons a physician can choose to withhold or delay the release of medical information. Reducing harm to patients and families is an AMA priority, and the recently enacted medical information release rules will cause harm if psychological or emotional issues are not included in the definition of harm.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Studying Physician Supervision of Allied Health Professionals Outside of
Their Fields of Graduate Medical Education

Referred to: Reference Committee B

-
- 1 Whereas, Advanced practice providers and allied health professionals are required under the
2 laws of many states to be supervised to some degree by a physician; and
3
4 Whereas, News reports and articles note instances of thoracic surgeons and obstetrician/
5 gynecologists supervising social workers in the provision of group therapy¹ and plastic surgeons
6 supervising physician assistants who advertise themselves as “dermatologists”²; and
7
8 Whereas, Widely known anecdotal evidence suggests numerous advanced practice providers
9 practicing in various fields while being nominally supervised by physicians not trained in those
10 fields; and
11
12 Whereas, Physicians without appropriate training supervising advanced practice providers
13 outside of their expertise defeats the purpose of scope-of-practice laws and endangers patients;
14 therefore be it
15
16 RESOLVED, That our American Medical Association conduct a systematic study to collect and
17 analyze publicly available physician supervision data from all sources to determine how many
18 allied health professionals are being supervised by physicians in field which are not a core part
19 of those physicians’ completed residencies and fellowships. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$100,000.

Received: 05/10/21

AUTHOR’S STATEMENT OR PRIORITY

As allied health providers have gained temporary independence and increased credit for their work during the pandemic, a proactive AMA attention and adequate data regarding supervision is needed to ensure that the supervision we are advocating for is indeed being provided and being done so for the specialty and procedures the physician is qualified to perform and oversee. The results of this study will be able to better inform our advocacy efforts and identify areas where our advocacy is not aligning with the standards we are holding ourselves to and will identify if we need to better regulate ourselves.

References:

1. Ornstein C and ProPublica. *Illinois leads Medicare billings for group therapy*. Chicago Tribune. 13 Jul 2014. <https://www.chicagotribune.com/lifestyles/health/ct-medicare-group-therapy-met-20140713-story.html>. Accessed 18 Sep 2019.
2. Al-agba N. *The P.A. Problem: Who You See and What You Get*. The Healthcare Blog. 24 Nov 2017. <https://thehealthcareblog.com/blog/2017/11/24/the-p-a-problem/>. Accessed 18 Sep 2019.

RELEVANT AMA POLICY

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987

Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care. (2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team. (3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians. (4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team. (5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities. (6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

Citation: BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13

Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio H-35.969

Our AMA will: (1) continue to work with the Federation in developing necessary state advocacy resource tools to assist the Federation in: (a) addressing the development of practice agreements between practicing physicians and advance practice nurses, and (b) responding to or developing state legislation or regulations governing these practice agreements, and that the AMA make these tools available on the AMA Advocacy Resource Center Web site; and (2) support the development of methodologically valid research comparing physician-APRN practice agreements and their respective effectiveness.

Citation: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 09, A-19

Physician Assistants and Nurse Practitioners H-160.947

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician. The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

- (1) The physician is responsible for managing the health care of patients in all settings.
- (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
- (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- (4) The physician is responsible for the supervision of the physician assistant in all settings.
- (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
- (6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
- (7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Regulation of Advanced Practice Nurses H-35.964

1. AMA policy is that advanced practice registered nurses (APRNs) should be subject to the jurisdiction of state medical licensing and regulatory boards for regulation of their performance of medical acts.

2. Our AMA will develop model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs.

Citation: BOT Action in response to referred for decision Amendment B-3 to Res. 233 A-17

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.

(2) The physician is responsible for managing the health care of patients in all practice settings.

(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.

(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.

(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.

(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.

(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.

(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.

(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.

(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.

(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

Citation: CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Health Workforce H-200.994

The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency. Citation: (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13)

Health Care Quality Improvement Act of 1986 Amendments H-275.965

The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists.

Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15)The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists. Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15)

Protecting Physician Led Health Care H-35.966

Our American Medical Association will continue to work with state and specialty medical associations and other organizations to collect, analyze and disseminate data on the expanded use of allied health professionals, and of the impact of this practice on healthcare access (including in poor, underserved, and rural communities), quality, and cost in those states that permit independent practice of allied health professionals as compared to those that do not. This analysis should include consideration of practitioner settings and patient risk-adjustment. Citation: Res. 238, A-15; Reaffirmed: BOT Rep. 20, A-17;

Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital H-35.978

The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital. Citation: (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(JUN-21)

Introduced by: Pennsylvania

Subject: Increasing Residency Positions for Primary Care

Referred to: Reference Committee B

1 Whereas, We have many physicians (known to be in the thousands within the United States)
2 that have completed the intense and specific education required in medical school whether at
3 allopathic or osteopathic institutions and have successfully passed USMLE part 1, 2 CK and 2
4 CS or comparable examinations, but have not been able to obtain a residency due to the
5 shortage of residency positions in the United States; along with a known shortage of
6 physicians within the United States currently and presumed well into the future due to our
7 aging population; and

8
9 Whereas, Even with the known shortage of physicians, and the increasing number of physicians
10 without residencies expands as more and more candidates go unmatched due to the cap on
11 Medicare support for graduate medical education residency positions are not increasing
12 adequately to support the physicians that are available nor correcting the need for more
13 practicing physicians; therefore be it

14
15 RESOLVED, That our American Medical Association prioritize the number of accredited
16 residency positions, with the goal to increase the overall number especially in specialties
17 deemed primary care (Directive to Take Action); and be it further

18
19 RESOLVED, That our AMA seek to increase the cap of Medicare support for graduate medical
20 education. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

We view this to be a high priority rather than a top priority since it has a significant impact on a subset of physician, yet it has direct implication to physician shortage and thus effects patient care through altering scope of practice issues. Extended care providers champion manpower deficiencies in rural and economically challenged urban areas. This resolution that attempts to match the number of residencies with the number of certified candidates has benefits to patient care as a whole. Clearly as the resolution ask, we are requesting that the AMA continue to advocate for increased GME funding and to direct that funding particularly toward increases in what would be considered primary care residencies.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(JUN-21)

Introduced by: Pennsylvania

Subject: Making State Health Care Cost Containment Datasets Free of Cost and Readily Available for Academic Research

Referred to: Reference Committee B

- 1 Whereas, All-payer claims databases (APCDs) are centralized databases created to enable
2 healthcare transparency and inform health policies at the state level; and
3
4 Whereas, APCDs are critical for emergent statewide research on topics including COVID-19;
5 and
6
7 Whereas, APCDs often self-publishes high-level summaries of various aspects of the collected
8 data in a format unsuitable for research; and
9
10 Whereas, APCDs deidentified dataset pricing structure is costly, curbing its use in academic
11 research by students and scientists, thereby limiting utilization of this important data to assess
12 novel questions; therefore be it
13
14 RESOLVED, That our American Medical Association advocate for affordable and open access
15 to all all-payer claims databases (APCDs) data for academic research purposes. (Directive to
16 Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

All-Payer Claims Databases, such as the PCH4 in Pennsylvania, allow for increased transparency of costs in the American healthcare system. Price transparency is a concept already supported by our AMA, but this resolution provides a specific example of existing raw datasets at the state level that are either inaccessible or too costly for effective utilization in academic research. We feel this is timely because, particularly in a time when health care may be experiencing a shift or even upheaval in the context of the current pandemic, academic researchers must have feasible access to the appropriate data to come to fair and effective conclusions regarding cost containment and proper use of healthcare resources.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(JUN-21)

Introduced by: Illinois

Subject: Ransomware and Electronic Health Records

Referred to: Reference Committee B

1 Whereas, Electronic health records are used as a repository of actionable medical records
2 which is used by healthcare providers to provide optimal care to patients; and
3

4 Whereas, Access to electronic records in a timely fashion at the point of care can provide
5 measurable and invaluable details about a patient's health history, including medications and
6 allergies, medical and surgical history, family and social history, any of which could be used in
7 treatment decisions which have measurable impact on the care provided and ultimately patient
8 outcomes; and
9

10 Whereas, Ransomware is a form of malware that encrypts a victim's files. The attacker then
11 demands a ransom from the victim to restore access to the data upon payment; and
12

13 Whereas, Ransomware can significantly interfere with the types and quality of care provided to
14 patients by physicians and other health care entities, even to the degree of putting a patient's
15 health and life at risk; therefore be it
16

17 RESOLVED, That our American Medical Association adopt policy acknowledging that
18 healthcare data interruptions are especially harmful due to potential physical harm to patients
19 and calling for prosecution to the fullest extent of the law for perpetrators of ransomware and
20 any other malware on independent physicians and their practices, healthcare organizations, or
21 other medical entities involved in providing direct and indirect care to patients (New HOD
22 Policy); and be it further
23

24 RESOLVED, That our AMA seek to introduce federal legislation which provides for the
25 prosecution of perpetrators of ransomware and any other malware on any and all healthcare
26 entities, involved in direct and indirect patient care, to the fullest extent of the law. (Directive to
27 Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution represents an issue that is timely and urgent.

Each and every day digital attacks occur in our health care delivery system. When a data breach occurs and system access is blocked it can be extremely harmful for patients.

Timely access to patient health care information and data is essential. Our current system for protecting patient EHR information from ransomware is not working. There need to be more severe penalties against perpetrators of malware and ransomware to deter future attacks and better protect patient information.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(JUN-21)

Introduced by: Illinois

Subject: Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients

Referred to: Reference Committee B

1 Whereas, A topical stock-item medication is an unlabeled ointment or drop that the hospital
2 operating room (OR), or Emergency Room (ER), or Ambulatory Surgical Treatment Center
3 (ASTC) staff has on stand-by or is retrieved from a dispensing system for a specified patient for
4 use during a procedure or visit; and

5
6 Whereas, Topical stock-item agents are charged to the patient, but unused medication often
7 gets discarded when the patient is discharged, even if the medication is recommended for post-
8 discharge care to aid in the patient's healing; and

9
10 Whereas, Because regulations governing the ability to dispense the remaining portion of stock-
11 item medications for post-discharge use can be unclear or appear overly burdensome, many
12 facilities do not allow the practice; and

13
14 Whereas, Patients may need to purchase duplicate agents for post-discharge use, increasing
15 patient cost and creating medication waste; and

16
17 Whereas, Similar issues of cost inefficiencies and medical waste arise with the use of
18 medications such as multiuse eye drops that are only allowed for single-patient use, but could
19 safely be used in multiple patients; and

20
21 Whereas, The Joint Commission has previously approved specific policies and procedures
22 implemented by the Utah Valley Regional Medical Center for the use of multi dose eye drops in
23 multiple patients; therefore be it

24
25 RESOLVED, That our American Medical Association work with national specialty societies,
26 state medical societies and/or other interested parties to advocate for legislative and regulatory
27 language that permits the practice of dispensing stock-item medications to individual patients
28 upon discharge in accordance with labeling and dispensing protocols that help ensure patient
29 safety, minimize duplicated patient costs, and reduce medication waste (Directive to Take
30 Action); and be it further

31
32 RESOLVED, That our AMA work with the Food and Drug Administration, national specialty
33 societies, state medical societies and/or other interested parties to advocate for legislative and
34 regulatory language that permits the practice of using multi dose eye drop bottles pre-
35 operatively in accordance with safe handling and dispensing protocols that help ensure patient
36 safety, minimize duplicated patient costs, and reduce medication waste. (Directive to Take
37 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution reflects an issue that is urgent. Health care costs have been rising at an unsustainable rate for years, jeopardizing patient access to care as costs escalate across all levels of the health care system. There is significant medical waste associated with the disposal of certain stock medications, which patients could continue to use safely if they were dispensed to the patient upon discharge. We should quickly pursue clarifying legislative and regulatory language that removes this barrier to the efficient and safe use of medications that would otherwise be wasted.

Reference:

Using multi dose eye drops in a health care setting: a policy and procedural approach to safe and effective treatment of patients.
Jensen MK, et al. JAMA Ophthalmology 2014. <https://jamanetwork.com/journals/jamaophthalmology/article-abstract/1901216>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(JUN-21)

Introduced by: American Academy of Dermatology, College of American Pathologists,
Missouri, Alaska, Arizona, California, Colorado, Guam, Hawaii, Idaho,
Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming,
Pennsylvania, Society for Investigative Dermatology, South Carolina, Iowa,
American Society for Dermatologic Surgery

Subject: ONC's Information Blocking Regulations

Referred to: Reference Committee B

1 Whereas, On May 1, 2020, the Office of the National Coordinator for Health Information
2 Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) published their
3 separate but interrelated final rules implementing provisions of the 21st Century Cures Act
4 (Cures) regarding interoperability, patient access to health data, data transparency electronic
5 health information blocking and the ONC Health IT Certification; and
6

7 Whereas, These twin regulations aim to advance greater and widespread sharing of health
8 information and transparency across the health care spectrum as well as promising to reduce
9 administration burdens; and
10

11 Whereas, Both final rules are extensive and highly complex, impacting software technology
12 developers, health information technology (HIT) vendors, payors, hospitals, medical practices,
13 physicians, and certain provisions raise compliance concerns for physicians with respect to
14 sharing, intervening and/or blocking patient's clinical information; and
15

16 Whereas, The ONC defines information blocking as "...a practice by a health IT developer of
17 certified health IT, health information network, health information exchange, or health care
18 provider that, except as required by law or specified by the Secretary of Health and Human
19 Services (HHS) as a reasonable and necessary activity, is likely to interfere with access,
20 exchange, or use of electronic health information (EHI);" and
21

22 Whereas, The ONC has established eight exceptions delineating activities that do not constitute
23 information blocking, provided that certain conditions are met; and
24

25 Whereas, These ONC exceptions are intended to support and sustain "seamless and secure
26 access, exchange, and use of electronic health information (EHI) and offer actors—health care
27 providers, health IT developers, health information exchanges (HIEs) or networks (HINs)—
28 certainty that practices that meet the conditions of an exception will not be considered
29 information blocking;" and
30

31 Whereas, The ONC has classified eight exceptions in two categories—either involving not
32 fulfilling requests to access, exchange, or use EHI or involving procedures for fulfilling requests
33 to access, exchange, or use EHI; and
34

35 Whereas, The "Preventing Harm Exception" requires that physicians share a wide variety of
36 medical information—including clinical progress notes, prescription medications and lab test

1 results—when readily available, in timely fashion and without delay, unless an exception to
2 delay or withhold the release of the patient’s information applies; and
3

4 Whereas, This requirement for immediate, automatic or “without delay” release of lab results to
5 patients with or without the knowledge of the ordering physician strains and undermines the
6 integrity of the physician-patients relationship and creates clinical workflow burdens and
7 compliance challenges for certain medical specialties that rely on surgical pathology lab testing,
8 results and inter-physician consultation with their pathologists; and
9

10 Whereas, Actors, including physicians, are afforded certain technical, compliance flexibilities
11 under the information blocking provisions and its concomitant exceptions based on necessity,
12 reasonableness, good faith efforts and professional clinical judgement within the scope and
13 context of treating patients and preventing harm; and
14

15 Whereas, The ONC delayed the original compliance date for its information blocking provisions
16 from November 2, 2020, to April 5, 2021, despite the AMA and other stakeholders urging a
17 delay beyond the April 5, 2021 deadline; and
18

19 Whereas, Both deadlines still fall within the current COVID-19 public health emergency (PHE)
20 that has caused uncertainties and challenges for the health care sector in general, with small
21 and medium-sized medical practices facing ongoing, acute economic hardship; and
22

23 Whereas, § 4004 of the Cures Act authorizes and grants regulatory discretion to the Secretary
24 of the Department of Health and Human Services (HHS) to identify reasonable and necessary
25 activities that do not constitute information blocking; therefore be it
26

27 RESOLVED, That our American Medical Association advocate for additional time and
28 compliance leeway for physicians by urging the Office of the National Coordinator for Health
29 Information Technology (ONC) to broaden and relax their current regulatory requirements based
30 on the following critical enumerated requests:

- 31 a. Urge the ONC to strike the right balance between the demands and distress caused by the
32 COVID-19 public health emergency (PHE) and its interoperability rule objectives.
- 33 b. Urge the ONC to earnestly consult with relevant stakeholders about unintended or
34 unforeseen consequences that may arise from the information blocking regulations.
- 35 c. Urge the ONC, through an interim final rule moratorium, to delay the current applicability
36 date of information blocking provisions until 12 months after the PHE is officially declared
37 over, affording small and medium-sized medical practices time to recover and prepare.
- 38 d. Urge the Department of Health and Human Services (HHS)’s ONC and their OIG to propose
39 future enforcement discretion that would afford small and medium-sized medical practices
40 further compliance flexibilities given their lack of resources.
- 41 e. Call on the HHS’s ONC and OIG in future enforcement rulemaking to propose corrective
42 action and further technical guidance rather than imposing fines or penalties.
- 43 f. Urge the ONC to broaden and relax its Patient Harm Exception through subregulatory
44 revisions that would include patients’ emotional and mental distress to the current and
45 narrow definition of this exception.
- 46 g. Call on the ONC to develop and offer more meaningful educational guidance, practical
47 resources, and technical assistance to physician practices to help them meet their
48 compliance efforts, patient care obligations and documentation requirements. (Directive to
49 Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

Prioritization for J21 is sought in order to immediately request delay for compliance and clarification for information blocking provisions in the recently implemented 21st Century Cures Act. Practices are struggling to invest in the technology for immediate release of all medical information (e.g. notes, prescriptions, and lab tests, etc.) at the time of financial strain caused by the current COVID-19 public health emergency. The pandemic has put undue financial burden on physician practices, especially small practices. Unanticipated investment in information technology was required to quickly transition to telehealth services. Right now, it's an unreasonable time for practices to spend even more for information technology services to comply with information blocking regulations. Many practices, especially primary care practices, are operating with inadequate margins. A [survey](#) by the [Physicians Foundation](#) estimated that 8 percent of all physician practices nationally — around 16,000 — have closed under the stress of the pandemic. Advocating for an extension for compliance is timely so that practices can first get on their feet, recoup financial losses and then incorporate recommended changes.

RELEVANT AMA POLICY

EHR Interoperability D-478.972

Our AMA:

- (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
 - (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
 - (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
 - (4) will continue efforts to promote interoperability of EHRs and clinical registries;
 - (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
 - (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
 - (7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
 - (8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
 - (9) will review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.
- Citation: Sub. Res. 212, I-15; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: Res. 221, I-16; Reaffirmed in lieu of: Res. 243, A-17; Reaffirmed: CMS Rep. 10, A-17; Appended: BOT Rep.

45, A-18; Reaffirmed: BOT Rep. 19, A-18; Appended: Res. 202, A-18; Appended: Res. 226, I-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 7, I-20;

Health Information Technology Principles H-478.981

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

1. Enhance physicians ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of Information Blocking.

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

Citation: BOT Rep. 19, A-18; Reaffirmation: A-19

1.1.1 Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare. A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate). However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include: (a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit. (b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment. (c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists. AMA Principles of Medical Ethics: I,II,IV,VIII Issued: 2016

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(JUN-21)

Introduced by: Association for Clinical Oncology, American Academy of Ophthalmology,
American College of Rheumatology

Subject: CMMI Payment Reform Models

Referred to: Reference Committee B

1 Whereas, The 2020 Medicare Trustees Report projects that the Part A trust fund will become
2 insolvent in 2026; and
3
4 Whereas, Physicians in communities across the country and medical specialty societies are
5 developing innovative ways to reduce costs; and
6
7 Whereas, Cost-containment strategies should not limit the ability for patients to receive access
8 to appropriate care, or for providers to prescribe such care; and
9
10 Whereas, New approaches for care delivery and reimbursement should be tested through
11 multiple, voluntary demonstration projects to yield insights about the impact of the policy
12 changes and allow for public comment prior to broader implementation; and
13
14 Whereas, Different specialties' processes of care are as diverse as the range of problems they
15 address, such that a payment system that works well for one specialty would not fit another
16 specialty; and
17
18 Whereas, Communities have different cultures, economics, and levels of social support and
19 therefore a payment solution that works well in one community may not work well in another
20 community; and
21
22 Whereas, The Physician-Focused Payment Model Technical Advisory Committee (PTAC) has
23 reviewed and assessed physician-focused payment models (PFPMs) based on stakeholder
24 proposals submitted to the committee, but the Center for Medicare and Medicaid Innovation
25 (CMMI) has not acted on their recommendations; and
26
27 Whereas, The Medicare Payment Advisory Commission (MedPAC) released a report in April
28 2021 recommending fewer models be offered by CMMI; and
29
30 Whereas, A new Administration creates opportunities to develop and test new models that
31 incentivize--not hamper--innovation that results in clinically meaningful improvements in patient
32 outcomes; therefore be it
33
34 RESOLVED, That our American Medical Association continue to advocate against mandatory
35 Center for Medicare and Medicaid Innovation (CMMI) demonstration projects (Directive to Take
36 Action); and be it further

1 RESOLVED, That our AMA advocate that the Centers for Medicare and Medicaid Services seek
2 innovative payment and care delivery model ideas from physicians and groups such as medical
3 specialty societies to guide recommendation of the Physician-Focused Payment Model
4 Technical Advisory Committee (PTAC) and work of the CMMI to propose demonstration
5 projects that are voluntary and can be appropriately tested (Directive to Take Action); and be it
6 further

7
8 RESOLVED, That our AMA advocate that CMMI focus on the development of multiple pilot
9 projects in many specialties, which are voluntary and tailored to the needs of local communities
10 and the needs of different specialties. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our AMA's current policy on Medicare demonstration projects focuses on including physicians and specialty societies in the development process of alternative payment models; however, it doesn't go far enough to make recommendations on the scale and scope of potential projects.

In recent months the Biden Administration has been pausing several prominent value-based reimbursement models run by CMS Innovation Center (CMMI) that had been approved and implemented by the Trump Administration in order to review model details. This intense audit of the previous administration's demonstration projects, coupled with the Medicare Payment Advisory Commission (MedPAC)'s April 2021 report recommending CMMI offer fewer models in the coming years, indicates that the new administration will likely put any newly proposed models through a longer and more rigorous review process prior to implementation. This provides a clear opportunity for our AMA to play an even more targeted role in shaping the proposals that will be considered.

If our AMA can seize on this opportunity to recommend that CMMI's newly proposed models focus on the development of multiple localized pilot projects across many specialties, we can help shape demonstration projects that physicians are incentivized to join voluntarily and that meet the needs of the communities they serve. This approach will be a benefit to care delivery across specialties and it is timely considering how early we still are in the new administration.

Above and beyond that, we need to begin the process now so that this new policy can be incorporated into our advocacy strategy. Given the timeliness and the low volume of projects that will be considered during the current administration, it is urgent that our AMA take up this resolution to ensure that future CMMI projects are voluntary and tailored to the needs of the specialized local communities that they serve.

The negative repercussions of demonstration projects that do not meet these requirements are likely long lasting and difficult to reverse.

¹ <https://fas.org/sgp/crs/misc/RS20946.pdf>

RELEVANT AMA POLICY

Physician-Focused Alternative Payment Models: Reducing Barriers H-385.908

1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.

3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMS.
 4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):
 - a. Continue to expand technical assistance
 - b. Develop IT systems that support and streamline clinical participation
 - c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided
 - d. Identify methods to reduce the data collection burden; and
 - e. Begin implementing the 21st Century Cures Act.
 5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:
 - a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patients health and success of treatment, such as disease stage and socio-demographic factors
 - b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and
 - c. Explore an approach in which the physician managing a patients care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.
 6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:
 - a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode
 - b. Distinguish between services ordered by a physician and those delivered by a physician
 - c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care
 - d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patients and physicians responsibility for managing the condition; and
 - e. Provide physicians with lists of attributed patients to improve care coordination.
 7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:
 - a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending
 - b. Account for costs that are not currently billable but that cost the practice to provide; and
 - c. Account for lost revenue for providing fewer or less expensive services.
- Citation: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 03, I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: BOT Rep. 13, I-20

Medicare Demonstration Projects D-330.948

Our AMA will: (1) encourage CMS to continue to seek input at the earliest possible occurrence from medical associations in the development of Medicare demonstration projects that are intended to contain costs and/or improve the appropriateness or quality of patient care; (2) encourage CMS to continue to vary the types of physician practices (e.g., by size, geographic location) that it utilizes in its Medicare demonstration projects; (3) encourage CMS to limit requirements that may make participation in Medicare demonstration projects financially and/or administratively impracticable for a wide range of physician practices; and (4) join state and specialty societies early on to assist with developing Medicare demonstration projects to protect the interests of patients and physicians.

Citation: (CMS Rep. 3, A-05; Reaffirmed: CMS Rep. 1, A-15)

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904

1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
 2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
 3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.
 4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.
- Citation: Res. 241, A-16;

Medicare Physician Payment Reform D-390.961

1. Our AMA will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.
 2. Our AMA will advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level.
 3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.
 4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.
 5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.
 6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians.
- Citation: CMS 6, A-09; Reaffirmation A-10; Reaffirmation I-13; Reaffirmed: CMS Rep. 05, I-16;

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904

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- Res. 241, A-16

Medicare Physician Payment Reform D-390.961

1. Our AMA will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.
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 3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.
 4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.
 5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.
 6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians.
- Citation: CMS 6, A-09; Reaffirmation A-10; Reaffirmation I-13; Reaffirmed: CMS Rep. 05, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(JUN-21)

Introduced by: Medical Student Section

Subject: Status of Immigration Laws, Rules, and Legislation During National Crises
and Addressing Immigrant Health Disparities

Referred to: Reference Committee B

1 Whereas, The 2018 American Community Survey (ACS) reported that about 10.6 million
2 undocumented immigrants were living the United States¹; and
3

4 Whereas, Since the beginning of the COVID-19 pandemic, there have been at least 48
5 immigration policy changes that have not only affected international travel, student visas, and
6 immigration, and asylum processes, but also caused significant confusion for immigration
7 lawyers²⁻⁴; and
8

9 Whereas, The suspension of the United States Custom and Immigration Services (USCIS)
10 during the COVID-19 pandemic has led to a back-up in the processing of necessary
11 documentation, which has left many unable to access certain benefits necessary for work,
12 receiving healthcare, and accessing public benefits⁵; and
13

14 Whereas, The Executive Office for Immigration Review (EOIR) suspended all hearings for non-
15 detained individuals on March 18, 2020, which delayed the processing of asylum seekers
16 enrolled in the Migrant Protection Protocols and left them to remain in Mexico in unsanitary
17 conditions that promotes the spread of the virus⁵; and
18

19 Whereas, The federal government used statutes and the Tariff Act of 1930 in order to create
20 rules from the Centers for Disease Control and Prevention (CDC) and CBP that restricted both
21 entry at the northern and southern borders and barred asylum seekers from entering the country
22 due to public health threats, despite evidence suggesting that such restrictions are ineffective
23 and may even divert resources from other interventions⁵; and
24

25 Whereas, Immigration courts closed at the beginning of the COVID-19 pandemic and postponed
26 hearings for detained people, prolonging their stay in detention centers^{4,5}; and
27

28 Whereas, The relief packages that were provided by the government during the pandemic either
29 provided little or no coverage to immigrants and their families, leaving them with few options for
30 testing and treatment^{5,7}; and
31

32 Whereas, The Families First Coronavirus Response Act (FFCRA) failed to make COVID-19
33 related services available under emergency Medicaid, which means that immigrants are unable
34 to access these services since they cannot apply for non-emergency Medicaid due to
35 immigration eligibility criteria^{1,5,8}; and
36

37 Whereas, Undocumented immigrants typically work low-earning jobs and are unable to receive
38 unemployment insurance or government stimulus checks during national crises^{5,9}; and

1 Whereas, The Coronavirus Aid, Relief, and Economic Security (CARES) act limited the ability to
2 receive a stimulus payment to individuals with a social security number, which limits many
3 immigrants who file taxes using Individual Taxpayer Identification Numbers (ITIN)^{1,5,8}; and
4

5 Whereas, Lapses in work authorization due to slowed processing times and suspension of
6 required processing services may result in immigrants being unemployed or losing benefits
7 offered by their employer^{5,8}; and
8

9 Whereas, Both the FFCRA and the CARES act expanded Unemployment Insurance (UI)
10 programs, but due to lapses in work authorizations, many immigrants may either not qualify or
11 lose access to this vital benefit¹; and
12

13 Whereas, Previous immigration law changes, such as the February 2020 Public Charge rule,
14 penalized immigrants for using non-cash public assistance like Medicaid, the Supplemental
15 Nutrition Assistance Program (SNAP), the Children's Health Insurance Program (CHIP), several
16 housing programs, and federal poverty level determination by threatening inadmissibility or
17 inability to be granted legal permanent residency in the United States^{10,11}; and
18

19 Whereas, These changes not only discourage use of publicly funded healthcare and welfare
20 services even among immigrant families to which the rule does not technically apply due to fear
21 and confusion, but also mislead countless immigrant parents to remove their U.S. citizen
22 children from health care insurance, likely leading to unnecessary child morbidity and
23 mortality^{10,12-15}; and
24

25 Whereas, Decreased participation in public benefit programs would contribute to a greater
26 uninsured population, a decrease in the use of both preventive and curative health services, and
27 negatively affect the health outcomes and financial stability of nearly 22 million noncitizens
28 currently residing in the U.S.^{10,16,17}; and
29

30 Whereas, On March 27, 2020, the USCIS announced that testing or treatment related to the
31 COVID-19 pandemic would not count as a public charge^{18,19}; and
32

33 Whereas, Although two filed lawsuits have prevented this ruling from being enacted further,
34 there remains a concern on the potential for future immigration policy to discriminate based on
35 poverty level, housing status, and the need for public benefits¹⁷⁻¹⁹; and
36

37 Whereas, Increased fear of deportation among families, even if only one family member is a
38 non-citizen immigrant, not only causes decreased health care utilization but also causes
39 increased behavioral issues in children¹⁷; and
40

41 Whereas, The 3rd AMA Principle of Medical Ethics states, "A physician shall respect the law
42 and also recognize a responsibility to seek changes in those requirements which are contrary to
43 the best interests of the patient" [10]; and
44

45 Whereas, Our AMA is opposed to any proposed rule, regulations, or policy that would deter
46 immigrants and/or their dependents from utilizing non-cash public benefits including but not
47 limited to Medicaid, CHIP, WIC, and SNAP (AMA Policy D-440.927); and
48

49 Whereas, Our AMA joined other health care organizations in submission of amicus briefs and
50 comment letters opposing the new public charge regulations, stating "there is no evidence that
51 chilling the use of health and nutrition benefits will result in an increase in income, employment

1 or educational status of immigrants. These sweeping and detrimental changes will ultimately
2 result in far greater costs to the public's health than any purported benefit offered by DHS" [11];
3 and
4

5 Whereas, Our AMA has set policy precedent to act on behalf of the health of immigrants,
6 refugees, migrant workers, and asylum seekers (AMA Policy H-350.957), and has joined other
7 health care organizations in submitting amicus briefs and comment letters opposing the new
8 public charge regulations, stating "there is no evidence that chilling the use of health and
9 nutrition benefits will result in an increase in income, employment or educational status of
10 immigrants... These sweeping and detrimental changes will ultimately result in far greater costs
11 to the public's health than any purported benefit offered by DHS"¹¹; therefore be it
12

13 RESOLVED, That our American Medical Association, in order to prioritize the unique health
14 needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a
15 pandemic:

- 16 (1) oppose the slowing or halting of the release of individuals and families that are currently
17 part of the immigration process; and
- 18 (2) oppose continual detention when the health of these groups is at risk and supports
19 releasing immigrants on recognizance, community support, bonding, or a formal
20 monitoring program during national crises that impose a health risk; and
- 21 (3) support the extension or reauthorization of visas that were valid prior to a national crisis
22 if the crisis causes the halting of immigration processing; and
- 23 (4) oppose utilizing public health concerns to deny of significantly hinder eligibility for asylum
24 status to immigrants, refugees, or migrant workers without a viable, medically sound
25 alternative solution (New HOD Policy); and be it further
26

27 RESOLVED, That our AMA amend H-350.957, "Addressing Immigrant Health Disparities," by
28 addition to read as follows:
29

30 Addressing Immigrant and Refugee Health Disparities H-350.957

31 1. Our American Medical Association recognizes the unique health needs of immigrants and
32 refugees and encourages the exploration of issues related to immigrant and refugee health
33 and supports legislation and policies that address the unique health needs of immigrants
34 and refugees.

35 2. Our AMA: (A) urges federal and state government agencies to ensure standard public
36 health screening and indicated prevention and treatment for immigrant children, regardless
37 of legal status, based on medical evidence and disease epidemiology; (B) advocates for and
38 publicizes medically accurate information to reduce anxiety, fear, and marginalization of
39 specific populations; and (C) advocates for policies to make available and effectively deploy
40 resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

41 3. Our AMA will call for asylum seekers to receive all medically appropriate care, including
42 vaccinations in a patient centered, language and culturally appropriate way upon
43 presentation for asylum regardless of country of origin.

44 4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities
45 among refugee or immigrant populations by forcing them to choose between health care or
46 future lawful residency status. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

The recent proposal and implementation of actions like asylum seeker bans, refugee entry suspensions, and postponing of Migration Protection Protocol hearings clearly demonstrate the need for a strong stance on immigrant protections during states of national emergency. Our delegation considers immigrant health and protections to be our strongest priority and ranked this resolution accordingly. To ensure our asks are actionable, the language of our resolution was crafted with the assistance of AMA advocacy staff.

This resolution strengthens AMA policy on legal immigrants' right to health care. It also broadens current policy so the AMA can continue to engage in conversations on immigration policy and their impact on immigrant health. The AAP has released several policy statements on the treatment of immigrant and refugee children, especially as it pertains to the use of detention centers and family separation policies, demonstrating that it is appropriate for our AMA to update existing policies on these issues.

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RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Res. 018, A-17

Opposing the Detention of Migrant Children H-60.906

Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.

Res. 004, I-18

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19

HIV, Immigration, and Travel Restrictions H-20.901

Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non-immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

CSA Rep. 4, A-03; Modified: Res. 2, I-10; Modified: Res. 254, A-18

HIV, Immigration, and Travel Restrictions H-20.901

Our AMA: (1) supports enforcement of the public charge provision of the Immigration Reform Act of 1990 (PL 101-649) provided such enforcement does not deter legal immigrants and/or their dependents from seeking needed health care and food nutrition services such as SNAP or WIC; (2) recommends that decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (3) recommends that non-immigrant travel into the United States not be restricted because of HIV status; and (4) recommends that confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.

Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(JUN-21)

Introduced by: Medical Student Section

Subject: Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs

Referred to: Reference Committee B

- 1 Whereas, Public assistance programs provide financial assistance to low-income individuals
2 and families to prevent falling below the poverty line due to costs of living, health care, and
3 food¹; and
4
- 5 Whereas, One in five Americans receives benefits from at least one public assistance
6 program¹; and
7
- 8 Whereas, Public assistance programs, like the Supplemental Nutrition Assistance Program
9 (SNAP), commonly known as “food stamps,” and the Temporary Assistance for Needy Families
10 (TANF), commonly known as “welfare,” provide financial assistance to low-income individuals
11 and families to address domestic hunger and similar basic needs²⁻³; and
12
- 13 Whereas, SNAP and TANF are partnerships where federal and state governments share
14 administrative responsibilities and expenses for beneficiaries^{2,3}; and
15
- 16 Whereas, SNAP usage is associated with improved nutrition, lower cost of health care among
17 recipients, and reduced risk for several chronic medical conditions including coronary artery
18 disease, cancer, asthma, and diabetes⁴; and
19
- 20 Whereas, Resource limitations and stringent requirements, such as federal law which requires
21 all TANF recipients work for a minimum of 30 hours per week or 20 hours per week for single
22 parents with children under the age of 6 years, prevent TANF from benefiting many low-income
23 families^{3,6}; and
24
- 25 Whereas, In order for individuals to qualify for SNAP, federal law requires work or participation
26 in employment and training programs for certain adults aged 18 to 59⁵; and
27
- 28 Whereas, Efforts to increase work requirements for recipients of public assistance programs can
29 have negative effects on recipients’ health outcomes and limit their ability to find stable
30 employment⁶⁻⁷; and
31
- 32 Whereas, Many recipients register for public assistance programs only after losing employment,
33 and more than 80 percent report securing employment within a year after starting to receive
34 SNAP benefits⁶⁻⁷; and
35
- 36 Whereas, Increased work requirements to qualify for public assistance programs create
37 administrative barriers that prevent even working recipients from receiving benefits, and have
38 the potential to restrict coverage for those with chronic medical conditions, including mental
39 illness and substance abuse disorders^{6-8, 17}; and

1 Whereas, Increased work requirements to qualify for public assistance programs are not shown
2 to improve health outcomes or reduce employment barriers^{6,9}; and
3

4 Whereas, Both federal and state governments share authority over work requirements for public
5 assistance programs, and states can exempt recipients from federal work requirements at their
6 discretion to allow more individuals to benefit from public assistance programs^{2,5,10}; and
7

8 Whereas, Our AMA opposes work requirements for the public assistance program Medicaid¹¹;
9 and
10

11 Whereas, In a 2018 letter to the US Senate, our AMA expressed support for the preservation of
12 SNAP and opposed proposed increases in work requirements that would reduce benefits for
13 recipients¹²; and
14

15 Whereas, While AMA undertook this action, existing policy on SNAP is vague, stating that “Our
16 AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance
17 Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy
18 and productive lives” and does not explicitly describe our opposition to increasing work
19 requirements¹³; and
20

21 Whereas, In 2019, the US Department of Agriculture considered new regulations that would
22 remove SNAP benefits from hundreds of thousands of recipients, by preventing states from (1)
23 exempting recipients from SNAP work requirements, (2) expanding SNAP eligibility standards
24 beyond the federal minimum, and (3) automatically qualifying individuals for SNAP based on
25 TANF eligibility, all of which are efforts taken by states to expand benefits to more low-income
26 individuals¹⁴⁻¹⁶; therefore be it
27

28 RESOLVED, That our American Medical Association support reduction and elimination of work
29 requirements applied to the Supplemental Nutrition Assistance Program and the Temporary
30 Assistance for Needy Families Program (New HOD Policy); and be it further
31

32 RESOLVED, That our AMA support states’ ability to expand eligibility for public assistance
33 programs beyond federal standards, including automatically qualifying individuals for a public
34 assistance program based on their eligibility for another program. (New HOD Policy)
35

Fiscal Note: Minimal - less than \$1,000

Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our delegation prioritizes protections of a social safety net for marginalized populations, including those of low socioeconomic status and who require public assistance. This resolution asks the AMA to support exemptions to work requirements and eligibility expansions in public assistance programs.

Our AMA already has policy opposing Medicaid work requirements, but does not have formal policy regarding work requirements for SNAP or other social support programs such as TANF. These programs already contain federally mandated work requirements, but states have traditionally been able to exempt beneficiaries from these requirements. States have also traditionally auto-qualified beneficiaries for SNAP based on their eligibility for TANF services to enroll individuals more easily in public assistance programs. Given prior attempts by the federal government to prevent states from taking these important actions, it is important to make an evidence-based AMA policy that supports work requirements exemptions for beneficiaries and easier access to public assistance programs.

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RELEVANT AMA POLICY

Opposition to Medicaid Work Requirements H-290.961

Our AMA opposes work requirements as a criterion for Medicaid eligibility. (Res. 802, I-17; Reaffirmation: A-18)

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

(Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18)

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

Our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients; (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible. (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches; (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs; (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (6) urges states to administer their Medicaid and SCHIP programs through a single state agency; (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs; (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include

additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services; (10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; (11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care; (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income; (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, AMA-MSS Digest of Policy Actions/ 190 congregate living facilities, social health maintenance organizations, and respite care; (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs; (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance; (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living; (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments; (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

(BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(JUN-21)

Introduced by: Medical Student Section

Subject: Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug
Related Felonies

Referred to: Reference Committee B

- 1 Whereas, Under current federal law, any individual convicted of a drug-related felony is not
2 eligible for benefits under the Supplemental Nutrition Assistance Program (SNAP)¹; and
3
4 Whereas, This provision was originally part of a much larger welfare-reform package passed in
5 1996 to deter individuals from drug-related crimes and decrease misuse of the welfare system⁴;
6 and
7
8 Whereas, As of March 2019, only 3 states and territories currently maintain this lifetime ban, 24
9 states have modified this ban on SNAP for persons convicted of a drug-related felony, and 25
10 states have repealed this ban altogether^{2,3}; and
11
12 Whereas, Many state-based modifications to this ban entail limiting the classes of drug felonies
13 subject to restriction, creating short-term bans, requiring drug-testing for enrollees, and requiring
14 enrollment and participation in drug treatment programs⁵; and
15
16 Whereas, Based on a regression discontinuity analysis performed with data comparing
17 recidivism in convicted drug traffickers in Florida immediately before and after the institution of
18 the federal SNAP ban, banning access to SNAP has been associated with an increased
19 likelihood of criminal recidivism⁶; and
20
21 Whereas, An economic study examining administrative data on released offenders in 43 states
22 has found that eligibility for SNAP and Temporary Assistance for Needy Families (TANF) “at the
23 time of release from prison significantly reduces the risk of returning to prison within one year by
24 up to 10%”⁷; and
25
26 Whereas, Food insecurity is defined by the condition of households that, at times, were “unable
27 to acquire adequate food for one or more household members because they had insufficient
28 money and other resources for food”⁸; and
29
30 Whereas, 11.1% of American households reported experiencing food insecurity at least at some
31 point during 2018, while a pilot study with a sample size of 110 former drug offenders indicated
32 a food insecurity prevalence of 91%^{5, 9, 10}; and
33
34 Whereas, Food insecurity is associated with higher risk of chronic disease, including diabetes,
35 obesity, depression, and hypertension^{11,12}; and
36
37 Whereas, Access to SNAP benefits has been associated with improved health as indicated
38 subjectively by higher ratings of self-assessed health, with significantly increased probability of

1 reporting excellent or very good health, and objectively by fewer days in bed due to illness¹⁰;
2 and

3
4 Whereas, Evidence suggests that although SNAP participants have fewer office-based medical
5 visits overall, , they have more preventative checkups and fewer diagnostic or emergency visits
6 than non-participants¹³; and

7
8 Whereas, Existing AMA policy (H-270.966) opposes requiring SNAP applicants or beneficiaries
9 to disclose medical information, including former drug use and treatment history, and opposes
10 denying assistance from these programs based on substance use status, and also supports the
11 preservation of SNAP to increase access to healthful foods and decrease food insecurity (H-
12 150.937); and

13
14 Whereas, Current AMA policy does not address the impact of current federal law regarding
15 criminal drug offenses and subsequent access to SNAP benefits; therefore be it

16
17 RESOLVED, That our American Medical Association oppose any lifetime ban on SNAP benefits
18 imposed on individuals convicted of drug-related felonies. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our delegation prioritizes protections of a social safety net for marginalized populations, including those of low socioeconomic status and who require public assistance. This resolution asks the AMA to oppose any federal lifelong ban on SNAP benefits for persons convicted of drug-related felonies given the potential for serious negative health and social consequences.

This resolution addresses a gap in AMA policy, and details why these individuals should not be restricted from accessing SNAP benefits once their sentence is concluded. SNAP is a program providing nutritional assistance to people who cannot afford it, and currently only persons convicted of drug-related felonies are subject to this federal ban--those convicted of murder, theft or other felonies can still get access to SNAP. Given that our AMA already supports SNAP, this policy is in-line with our belief that SNAP should be accessible to reduce food insecurity.

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RELEVANT AMA POLICY

Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs H-270.966

Our AMA opposes: a) requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance; and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, "welfare") and/or the Supplemental Nutrition Assistance Program (SNAP, "food stamps") to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status. (Res. 245, A-97; Reaffirmed: BOT Rep. 33, A-07; Modified: Res 203, A-16)

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives. (Res. 414, A-10; Reaffirmation, A-12; Reaffirmation, A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation, A-14; Reaffirmation, I-14; Reaffirmation, A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(JUN-21)

Introduced by: Medical Student Section

Subject: Amending H-150.962, Quality of School Lunch Program to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs During COVID-19

Referred to: Reference Committee B

1 Whereas, The USDA Food and Nutrition Service (FNS) administers 15 federal nutrition-
2 assistance programs across the country¹; and
3
4 Whereas, The National School Lunch Program (NSLP) and the School Breakfast Program
5 (SBP), provide vital sources of food for low-income children during the school year¹; and
6
7 Whereas, In the 2018-19 school year, the NSLP, which had a \$12.5 billion budget in 2016,
8 served 4.9 billion lunches to 29.6 million children around the country, and the SBP served 2.5
9 billion breakfasts to 14.8 million children^{1,2}; and
10
11 Whereas, The U.S. Department of Agriculture (USDA) National School Lunch Program, School
12 Breakfast Program, and Child and Adult Care Food Program serve nearly 35 million children
13 daily³; and
14
15 Whereas, Children living with families whose incomes are at or below 130 percent of the federal
16 poverty level (currently \$26,200 for a family of four) are eligible for free meals, and those with
17 incomes between 130 and 185 percent of the federal poverty level are eligible for reduced-price
18 meals^{1,2}; and
19
20 Whereas, Children automatically qualify for free meals if their household participates in the
21 Supplemental Nutrition Assistance Program (SNAP), and they may be matched through other
22 programs, such as the Temporary Assistance for Needy Families cash assistance program or
23 the Food Distribution Program on Indian Reservations¹; and
24
25 Whereas, Schools and school districts that have at least 40 percent of students deemed
26 automatically eligible for free lunch may participate in the Community Eligibility Provision (CEP),
27 which allows schools to serve universal free meals without collecting household applications¹;
28 and
29
30 Whereas, CEP allowed more than 13.6 million students in more than 28,000 schools to receive
31 free lunch in the 2018–19 school year¹; and
32
33 Whereas, Based on an online survey (n=584), pick-up school-provided meals during the
34 pandemic were received by 40.0% of families, while 27.8% received SNAP benefits, 11.7%
35 received WIC benefits, and 16.5% received meals from local food banks or food assistance
36 programs⁴; and

1 Whereas, The COVID-19 pandemic contributed to a 17% overall decrease in the percentage of
2 food secure families, while the overall percentage of families experiencing very low food
3 security increased by 20%⁴; and
4

5 Whereas, Food insecurity is negatively associated with health outcomes, including poor mental
6 health outcomes such as depression, stress, and anxiety, poor diet quality, high rates of chronic
7 diseases such as diabetes and obesity, and a lower overall health status⁵; and
8

9 Whereas, The COVID-19 pandemic, and the associated social and economic responses have
10 the potential to dramatically increase food insecurity and its related health disparities among
11 already at-risk populations⁵; and
12

13 Whereas, Studies have shown that the United States' food system is not resilient against the
14 expected level of worker unemployment during a pandemic. With the unprecedented rise in U.S.
15 unemployment rate, and the fact that rates of food insecurity parallels unemployment and
16 economic trends, food insecurity is predicted to climb higher as the pandemic progresses^{5,6}; and
17

18 Whereas, Around 60.1% of families experienced a decrease in income during the pandemic,
19 23.4% of which were low food secure and 42.5% were very low food secure⁴; and
20

21 Whereas, Families that were already experiencing food insecurity before COVID-19 are more
22 likely to have worsened insecurity during the pandemic, specifically 46.5% of these families
23 experienced very low food security during this time⁴; and
24

25 Whereas, Individuals with low or very low food security are more likely to be non-Hispanic Black
26 or Hispanic, be of lower socioeconomic status, have children in the home, not have health
27 insurance or have Medicaid, and are more likely to be receiving SNAP benefits⁷; and
28

29 Whereas, This racial disparity in food security status is yet another example in which COVID-19
30 is disproportionately impacting minority and other marginalized communities in the United
31 States⁷; and
32

33 Whereas, In comparison with 8% of white students, 45% of African American and Hispanic
34 children attended high-poverty schools, where ≥75% of the student population have free or
35 reduced-price lunch eligibility⁸; and
36

37 Whereas, Some solutions that have been enacted in order to provide meals for students that
38 are not physically attending school have included waivers for school districts, such as allowing
39 schools to serve meals outside of their standard times, that allow for expansion of normal meal
40 assistance programs¹; and
41

42 Whereas, The increased need for meals and short time constraint of the pandemic have led to
43 decreased reimbursement rates per meal, which only exacerbates the increased cost of these
44 programs caused by staffing and delivery difficulties¹; and
45

46 Whereas, Some school districts offer the Summer Food Service Program (SFSP) and the
47 Seamless Summer Option (SSO), which are typically used to continue serving meals to children
48 during unanticipated school closures¹; and

1 Whereas, Despite various efforts to provide access to meals for families and children not at
2 school, only 11% of newly unemployed families were reporting access to “grab-and-go” meals
3 during the pandemic⁹; and
4

5 Whereas, The Pandemic Electronic Benefit Transfer (P-EBT) program was reauthorized in the
6 Families First Coronavirus Act, and enables states to enact emergency standards of eligibility
7 for children who have lost access to free- or reduced-price meals because their schools closed
8 for at least five consecutive days in response to the COVID-19 pandemic¹; and
9

10 Whereas, The P-EBT program provides households for whom schools are closed for 20 days in
11 a month a total benefit of \$115.60 per child¹; and
12

13 Whereas, Certain restrictions that exist for those using federal meal benefits, such as
14 purchasing restrictions, may lead to decreased ability to purchase certain types of food or
15 purchase food through some means¹⁰; and
16

17 Whereas, Available programs and offerings that the federal government have put in place have
18 not been widely or equally adopted by states, leading to exacerbation of disparities on a
19 geographical basis¹⁰; and
20

21 Whereas, Shifting the main responsibility of providing nutrition to children to the SNAP program
22 may have negative health implications, since SNAP does not adhere to strict nutrition guidelines
23 in the same ways that school meal programs must³; and
24

25 Whereas, There has not been a mandate released by the USDA to offer food service during
26 school closures or for students who are not physically present at schools³; and
27

28 Whereas, The United States Food and Nutrition Service (FNS) released a statement that
29 reaffirmed their commitment to allowing states to serve free meals to children, launching
30 Pandemic-EBT (P-EBT), increasing SNAP benefits, addressing supply challenges, providing
31 billions of dollars in food through local food banks, food pantries, and disaster household
32 distributions, and approving nearly 3,000 flexibilities and program adjustments to ease
33 operations and protect the health of applicants and participants¹¹; and
34

35 Whereas, Previous AMA policies established precedent for the AMA’s support of healthy meals
36 and the availability of nutrition through school lunch programs for children (AMA Policies H-
37 150.962 and H-150.937); therefore be it
38

39 RESOLVED, That our American Medical Association amend policy H-150.962, “Quality of
40 School Lunch Program,” by addition as follows:
41

42 **Quality of School Lunch Program H-150.962**

43 1. Our AMA recommends to the National School Lunch Program that school meals be
44 congruent with current U.S. Department of Agriculture/Department of HHS Dietary
45 Guidelines.

46 2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate
47 access to federal child nutrition programs.

48 3. Our AMA support adoption and funding of alternative nutrition and meal assistance
49 programs during a national crisis, such as a pandemic. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

Our delegation prioritizes protections for a social safety net, and this resolution addresses the issue of food insecurity for children during national emergencies. This resolution seeks to amend existing AMA policy H-150.962 to better address a gap in policy and allows our AMA to advocate for increased nutritional assistance programs.

The COVID-19 pandemic has certainly highlighted systemic inequalities, including food insecurity. Particularly in children, food insecurity has been shown to have adverse health and behavioral outcomes. The United States has seen an increase in food insecurity of almost 30% in households with children, a significant portion of which disproportionately impacts children of color, further contributing to the burden of disparities faced during this pandemic by communities of color. In a time such as a pandemic, when state and federal level nutrition and meal assistance programs are in high demand, the asks for increased funding and further advocacy supporting the adoption of these programs is warranted.

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RELEVANT AMA POLICY

Quality of School Lunch Program H-150.962

1. Our AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines.
2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate access to federal child nutrition programs.

Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 206, I-17

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

Food Environments and Challenges Accessing Healthy Food H-150.925

Our AMA encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts.

Res. 921, I-18

Combating Obesity and Health Disparities H-150.944

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.

Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(JUN-21)

Introduced by: Medical Student Section

Subject: Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity

Referred to: Reference Committee B

1 Whereas, The United States government manages the largest immigration detention system in
2 the world¹; and
3

4 Whereas, The U.S. Customs and Border Patrol (CBP) and U.S. Immigration and Customs
5 Enforcement (ICE), both under the jurisdiction of the Department of Homeland Security (DHS),
6 are meant primarily to process non-US citizens (immigrants, migrants, and asylum seekers) and
7 the intention of their detention centers is to temporarily hold people until their cases are heard or
8 they are deported^{2,3}; and
9

10 Whereas, For ICE detention facilities, a 2019 report by DHS Office of the Inspector General
11 found 14,000 health and safety deficiencies mainly related to physical and mental health care
12 procedures for detainees⁴; and
13

14 Whereas, 23 deaths (42% of deaths) occurred due to substandard care in ICE immigrant
15 detention centers between 2010 and 2018⁵; and
16

17 Whereas, For CBP detention facilities, a 2019 report by DHS Office of Inspector General
18 showed that prolonged detention in overcrowded CBP facilities has resulted in unhealthy living
19 conditions, including sparse bathing and cleaning supplies, which has been confirmed by
20 attorneys of the detainees^{6,7}; and
21

22 Whereas, Increased duration of detention is associated with increased symptom severity with
23 respect to mental health conditions including post-traumatic stress disorder and depression⁸;
24 and
25

26 Whereas, No empirical evidence supports the assumption that the threat of being detained
27 deters irregular migration⁹; and
28

29 Whereas, Policy organizations across the political spectrum agree that there are viable
30 alternatives to immigrant detention centers overseen by the Department of Homeland Security
31 (DHS)¹⁰⁻¹²; and
32

33 Whereas, Alternatives to Detention (ATD) programs include the Intensive Supervision
34 Appearance Program, Bonds, Family Case Management Program, and Community
35 Management Programs, which include one or more of caseworker assignments, home check-
36 ins, ICE check-ins, and/or telephonic monitoring^{10,11,13,14}; and

1 Whereas, International program data on ATDs demonstrate improved health outcomes,
2 decreased costs, increased compliance with immigration check-ins and hearings, and preserved
3 family unity compared to detainment^{9,14,15}; and
4

5 Whereas, The United States Government Accountability Office reported that the daily cost of
6 ATDs is less than 7% of that of detention centers, thus ATDs cost less than seven cents for
7 every dollar required to operate detention centers¹⁵; and
8

9 Whereas, The FCMP also demonstrated that ATD programs could be more economic than
10 detention centers, costing approximately \$38.47 per family per day as compared to \$237.60 per
11 family per day¹⁶; and
12

13 Whereas, 99% of the 630 asylum seekers who participated in the Family Case Management
14 Program (FCMP), an ICE-run ATD program, complied with ICE monitoring requirements¹⁶; and
15

16 Whereas, Previously implemented ATD programs such as the Community Support Initiative and
17 the Appearance Assistance Program showed similarly high rates of compliance to FMCP^{12,17};
18 and
19

20 Whereas, The American Academy of Pediatrics, the American College of Physicians, and
21 Doctors for Camp Closure have recommended the use of ATD programs for immigrants, and
22 particularly for children^{18,19}; and
23

24 Whereas, ATD programs would achieve the healthcare quality goals of AMA policy D-350.983
25 for improving medical care in immigrant detention centers, and better align with our policy H-
26 65.965 on human dignity and human rights; and
27

28 Whereas, The term ATD is broadly defined and inclusive of alternatives that could be
29 considered exploitative or inhumane, such as applying high bail bonds or excessive
30 surveillance, thus creating a need to distinguish between ATD programs that respect human
31 dignity and those that do not¹⁰; and
32

33 Whereas, Our AMA supports “the dignity of the individual, human rights and the sanctity of
34 human life,” (H-65.965); therefore be it
35

36 RESOLVED, That our American Medical Association advocate for the preferential use of
37 Alternatives to Detention programs that respect the human dignity of immigrants, migrants, and
38 asylum seekers who are in the custody of federal agencies. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

The U.S. government manages the largest immigration detention system in the world, which is meant to temporarily hold non-US immigrants, migrants, and asylum seekers until their case is heard or until deportation. Alternatives to Detention Centers are defined, established programs that respect human dignity in a way that current detention centers do not by virtue of not placing undocumented immigrants in what amounts to jail cells and isolation from family and loved ones.

This resolution asks our AMA to support humane alternatives to detention centers, such as Intensive Supervision Appearance Program, Bonds, Family Case Management Program, and Community Management Programs. We request that the House of Delegates consider this resolution in light of COVID-19 and unsafe hygienic conditions that detainees are made to live in. Detention centers are ripe environments for spread of COVID-19 and other communicable diseases given crowding and poor hygiene.

Our delegation considers this resolution a priority due to the ongoing nature of this problem: if Our AMA HoD does not address this issue urgently, additional children will be taken from their mothers, additional families and additional detainees will suffer or die from unhygienic conditions. These alternative to detention programs are feasible, cheaper than current detention methods, more humane, and will not have the extensive negative impact on physical and mental health of immigrants and asylum seekers that detention does.

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RELEVANT AMA POLICY

Improving Medical Care in Immigrant Detention Centers D-350.983

Our AMA will: (1) issue a public statement urging U.S. Immigration and Customs Enforcement Office of Detention Oversight to (a) revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care, (b) take necessary steps to achieve full compliance with these standards, and (c) track complaints related to substandard healthcare quality; (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care; and (3) advocate for access to health care for individuals in immigration detention.

Res. 017, A-17

Care of Women and Children in Family Immigration Detention H-350.955

1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.

Res. 002, A-17

Opposing the Detention of Migrant Children H-60.906

Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.

Res. 004, I-18

Support of Human Rights and Freedom H-65.965

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

CCB/CLRPD Rep. 3, A-14 Reaffirmed in lieu of: Res. 001, I-16 Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(JUN-21)

Introduced by: Medical Student Section

Subject: Oppose Tracking of People who Purchase Naloxone

Referred to: Reference Committee B

- 1 Whereas, The number of opioid deaths has been steadily increasing over the past two decades;
2 approximately 130 Americans die each day from opioid overdose¹; and
3
4 Whereas, Naloxone hydrochloride is a competitive antagonist against the mu-opioid receptor
5 that can be used to counteract the effects of opioids to reverse an overdose^{2,3}; and
6
7 Whereas, Due to the rising prevalence of opioid use disorder (OUD), the FDA approved the use
8 of naloxone products by bystanders who suspect opioid overdose⁴; and
9
10 Whereas, Naloxone has an established history of safe and effective use to combat opioid
11 overdoses and has no abuse potential^{5,6}; and
12
13 Whereas, Naloxone has few adverse effects and is very effective at reversing the actions of
14 opioids⁷; and
15
16 Whereas, When naloxone is given to healthy volunteers with no recent opioid
17 exposure, naloxone has no clinical effect, but when given to someone who is unresponsive for a
18 reason other than opioid toxicity, naloxone is unlikely to cause harm^{7,8}; and
19
20 Whereas, A prospective, randomized trial showed that intramuscularly or intranasally
21 administered naloxone showed low rates of minor adverse events (e.g. headache, nausea,
22 irritation) and major events (e.g. seizure) were not found⁶; and
23
24 Whereas, A systematic review on the management of opioid overdose with Naloxone reports
25 low rates of death or adverse outcomes (0% to 1.25%) for patients who were administered
26 naloxone and not brought to a healthcare facility⁹; and
27
28 Whereas, The World Health Organization (WHO) has recommended the widespread availability
29 of naloxone to counteract opioid related deaths¹⁰; and
30
31 Whereas, Take-home naloxone programs are effective for reducing opioid-overdose mortality,
32 and the efficacy of reversal by laypersons is 75-100%^{4,8}; and
33
34 Whereas, Between 1996 and 2014, 644 local sites in 30 states and the District of Columbia
35 distributed 152,000 naloxone kits and reported 26,000 successful drug overdose reversals¹¹;
36 and
37
38 Whereas, As of July 2017, all 50 states and the District of Columbia have passed laws that
39 increase public access to naloxone and 43 states have issued standing orders allowing non-
40 medical persons to obtain and administer naloxone^{12,13}; and

1 Whereas, Reviews have found that expanding the supply of naloxone is not associated with
2 compensatory drug use or greater risk-taking^{14,15}; and

3
4 Whereas, Many people who purchase and use naloxone are friends, family, and community
5 members who are not at risk of opioid overdose themselves, which means that the purchase of
6 naloxone is not indicative of overdose risk¹⁶⁻¹⁸; and

7
8 Whereas, Federal law (42 Code of Federal Regulations, Part 2) protects patient confidentiality
9 as it pertains to substance use treatment and does not require this information be placed in the
10 electronic medical record¹⁹; and

11
12 Whereas, Naloxone purchased without a prescription will be recorded at the pharmacy of
13 purchase²⁰; and

14
15 Whereas, The state of Nebraska maintains a prescription drug monitoring program, which will
16 track all dispensed prescriptions in the state including those for naloxone²⁴; and

17
18 Whereas, In Massachusetts, a state with a standing order allowing healthcare workers to
19 purchase naloxone, more than a half dozen employees at Boston Medical Center were denied
20 life and disability insurance due to receipt of naloxone; this is a problem that has occurred in
21 multiple states^{25,26}; and

22
23 Whereas, The presence of any evidence of substance use treatment including naloxone
24 purchases on a medical or insurance record may bias the provider and result in alteration of the
25 care provided²¹⁻²³; and

26
27 Whereas, Physicians who believe their patients have an OUD are less likely to provide them
28 with appropriate pain management and are more likely to assume symptoms are due to their
29 OUD²⁷; and

30
31 Whereas, There is no data to support that tracking naloxone purchase history provides any
32 health benefits, but it may reduce people's willingness to purchase naloxone^{25,28}; and

33
34 Whereas, Our AMA (H-95.932) along with the WHO and CDC respect recognize the importance
35 of increased access to naloxone and advocate for its widespread availability^{29,30}; therefore be it

36
37 RESOLVED, That our American Medical Association oppose any policies that require
38 personally identifiable information associated with naloxone prescriptions or purchases to be
39 tracked or monitored by non-health care providers. (New HOD Policy)

40
Fiscal Note: Minimal - less than \$1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution takes an important step to destigmatize the purchase of naloxone during the opioid crisis by proposing that the AMA support guidelines allowing any person be able to purchase naloxone without being tracked or monitored, and that the AMA oppose any policies that may require such prescriptions be tracked or monitored.

This resolution details the unnecessary tracking and monitoring of naloxone purchasing in certain states, how tracking naloxone purchases may discourage people from buying the life-saving drug, thus decreasing its accessibility. Because the AMA strongly supports the widespread availability and usage of naloxone to decrease the number of opioid related deaths (H-95.932) but has not yet taken a stance on potential tracking and monitoring of naloxone purchases, we believe that this resolution falls within the scope and spirit of the AMA and addresses an important gap in current policy.

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RELEVANT AMA POLICY

Increasing Availability of Naloxone H-95.932

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription. (BOT Rep. 22, A-16, Modified: Res. 231, A-17, Modified: Speakers Rep. 1, A-17, Appended: Res. 909, I-17, Reaffirmed: BOT Rep. 17, A-18, Modified: Res. 524, A-19)

Prevention of Opioid Overdose D-95.987

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose. (Res. 526, A-06, Modified in lieu of: Res. 503, A-12, Appended: Res. 909, I-12, Reaffirmed: BOT Rep. 22, A-16, Modified: Res. 511, A-18, Reaffirmed: Res. 235, I-18)

Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947

Our AMA:

- (1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
- (2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
- (3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperable, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
- (4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
- (5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
- (6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
- (7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;
- (8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
- (9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs. (BOT Rep. 3, A-08, Reaffirmed: BOT Rep. 12, A-15, Reaffirmation: A-16, Appended BOT Rep. 13, A-17)

Prescription Drug Monitoring Program Confidentiality H-95.946

Our AMA will:

- (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial;
- (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and
- (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred. (Res. 22, A-12, Reaffirmed: BOT Rep. 12, A-15, Reaffirmed: BOT Rep. 5, I-15)

Drug Abuse Related to Prescribing Practices H-95.990

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:

- A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.
- B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard,

emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:

A. promotes physician training and competence on the proper use of controlled substances;

B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;

C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and

D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.

3. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances. (CSA Rep. C, A-81, Reaffirmed: CLRPD Rep. F, I-91, Reaffirmed: Sunset Report, I-01, Reaffirmed: CSAPH Rep. 1, A-11, Appended: Res. 907, I-11, Appended: Res. 219, A-12, Reaffirmation: A-15, Reaffirmed: BOT Rep. 12, A-15, Reaffirmed: BOT Rep. 5, I-15, Reaffirmed: BOT Rep. 17, A-18, Modified: Speakers Rep., A-18)

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980

Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs. (BOT Rep. 11, A-10)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(JUN-21)

Introduced by: Medical Student Section

Subject: Equal Access to Adoption for the LGBTQ Community

Referred to: Reference Committee B

1 Whereas, Current federal qualifications for adoption, according to U.S. Citizenship and
2 Immigration Services (USCIS) are as follows:

- 3
- 4 1. You must be a U.S. Citizen.
 - 5 2. If you are unmarried, you must be at least 25 years old.
 - 6 3. If you are married, you must jointly adopt the child (even if you are separated but not
7 divorced), and your spouse must also be either a U.S. citizen or in legal status in the
8 United States.
 - 9 4. You must meet certain requirements that will determine your suitability as a prospective
10 adoptive parent, including criminal background checks, fingerprinting, and a home
11 study¹; and
- 12

13 Whereas, The federal government currently allocates funding for adoption and foster care to
14 states, which independently manage federal funds and have differing statutes concerning
15 eligibility to adopt or place a child up for adoption²⁻⁴; and

16

17 Whereas, Independent state-licensed child welfare agencies are contracted by each state to
18 provide foster care or adoption services⁵; and

19

20 Whereas, The American Bar Association recently adopted a resolution in 2019 criticizing how
21 “state-sanctioned discrimination against LGBT individuals who wish to raise children has
22 dramatically increased in recent years”⁶⁻⁷; and

23

24 Whereas, Eleven states currently permit state-licensed welfare agencies to refuse placement of
25 children with LGBTQ individuals and same-sex couples and fourteen additional states lack
26 explicit protection for LGBTQ individuals concerning adoption rights⁵; and

27

28 Whereas, In fiscal year 2018 alone, the need for adoption was evident as there were 437,283
29 total children in the U.S. foster care system with 125,422 children waiting to be adopted⁸; and

30

31 Whereas, According to 2019 Adoption and Foster Care Analysis and Reporting System
32 (AFCARS) data, 58% or 143,572 children spent over 12 months in foster care before leaving the
33 system⁸; and

34

35 Whereas, The longer a child is in foster care, the more likely that child is to move from one
36 foster placement to another, and the greater the risk that child experiences adverse childhood
37 events (ACEs), which may result in lasting negative social and emotional consequences⁹; and

1 Whereas, Per evaluation with the Child Behavior Checklist (CBCL), children who enter foster
2 care with no known internal or external problems show an increase in “total problem behavior” in
3 direct correlation with their number of placements¹⁰⁻¹²; and
4

5 Whereas, Frequent placement changes result in difficulty forming secure attachments with
6 foster parents, low-self esteem, and a negative relationship with academic growth¹⁰⁻¹²; and
7

8 Whereas, Per the Centers for Disease Control and Prevention, “Creating and sustaining safe,
9 stable, nurturing relationships and environments for all children and families can prevent ACEs
10 and help all children reach their full potential”¹³; and
11

12 Whereas, Recent social science literature supports that children living with same-sex parents
13 have equivalent outcomes compared to children with different-sex parents¹⁴; and
14

15 Whereas, Estimates from the 2010 U.S. Census suggest there are nearly 650,000 same-sex
16 couples living in the U.S., and same-sex couples are five times (10% vs 2%) more likely to
17 adopt children under age 18 compared to different sex couples¹⁵⁻¹⁶; and
18

19 Whereas, Current AMA Policy H-60.959 calls for the “comprehensive and evidence-based care
20 that addresses the specific health care needs of children in foster care” and supports the “best
21 interest of the child” as the most important criterion determining custody, placement, and
22 adoption of children;” and
23

24 Whereas, AMA policy H-60.940 supports the rights of a non-married partner to adopt the child of
25 their co-parenting partner but does not adequately address adoption rights of LGBTQ
26 individuals nor their limited eligibility or access to adoption, allowing for potential harm towards
27 children by narrowing the pool of qualified foster and adoptive homes; therefore be it
28

29 RESOLVED, That our American Medical Association advocate for equal access to adoption
30 services for LGBTQ individuals who meet federal criteria for adoption regardless of gender
31 identity or sexual orientation (Directive to Take Action); and be it further
32

33 RESOLVED, That our AMA encourage allocation of government funding to licensed child
34 welfare agencies that offer adoption services to all individuals or couples including those with
35 LGBTQ identity. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution address equal access to adoption for the LGBTQ community. Our delegation believes it is imperative to continue to decrease the stigma and discrimination not only for those children who have yet to be adopted, but for the innumerable children parented by same-sex couples today. Moreover, there is also a vital function of a more equitable and available adoption process for same sex couples. By expanding the federal requirements for non-discrimination in relation to same sex parents, great strides could be made in addressing the epidemic of LGBTQ youth homelessness. Furthermore, the Supreme Court recently heard arguments on this very topic, experts believe the Supreme Court is likely to rule in favor of the Catholic adoption agency and thus against LGBTQ+ same sex parents/couples. This resolution would bolster existing AMA advocacy efforts.

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RELEVANT AMA POLICY

Uniformity of State Adoption and Child Custody Laws H-60.959

The AMA urges: (1) state medical societies to support the **adoption** of a Uniform **Adoption** Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform **Adoption** Act; and (3) state medical societies to support **adoption** of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and **adoption** of children.

Sub. Res. 219, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13

Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based **care** that addresses the specific health **care** needs of children in **foster care**.

Res. 907, I-17

Partner Co-Adoption H-60.940

Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child. Res. 204, A-04; Modified: CSAPH Rep. 1, A-14

Health Care disparities in Same-Sex Partner Households H-65.973

Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.

CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09; Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12

Adoption H-420.973

It is the policy of the AMA to (1) support the provision of **adoption** information as an option to unintended pregnancies; and (2) support and encourage the counseling of women with unintended pregnancies as to the option of **adoption**.

Res. 146, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10

Support of Human Rights and Freedom H-65.965

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

CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of Res. 001, I-16; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(JUN-21)

Introduced by: Medical Student Section
Subject: Support for Mental Health Courts
Referred to: Reference Committee B

1 Whereas, “Mental health courts” are correctional diversion and rehabilitation programs used by
2 state and local courts to support individuals with mental illness in the justice system¹⁻⁷; and
3

4 Whereas, Mental health courts connect individuals with mental illness to mental health
5 treatment, as an alternative to incarceration or other legal sentences and penalties¹⁻⁷; and
6

7 Whereas, Two pieces of federal Congressional legislation, the America’s Law Enforcement and
8 Mental Health Project of 2000 and the Mentally Ill Offender Treatment and Crime Reduction Act
9 of 2004 (MIOTCRA), were enacted to improve the use of mental health personnel and
10 resources in the justice system and to establish grants to fund mental health court programs⁸⁻⁹;
11 and
12

13 Whereas, The continued funding of MIOTCRA programs over the last two decades has been
14 dependent on Congressional appropriations¹⁰; and
15

16 Whereas, The US Substance Abuse and Mental Health Services Administration (SAMHSA) in
17 the Department of Health and Human Services and the US Bureau of Justice Assistance (BJA)
18 in the Department of Justice administer grants to fund state and local mental health courts^{11,12};
19 and
20

21 Whereas, Research demonstrates that mental health courts appear to be associated with
22 reductions in recidivism, length of incarceration, severity of charges, risk of violence, and
23 rehospitalization among individuals with mental illness in the justice system^{3,13-26}; and
24

25 Whereas, SAMHSA published a 2015 report noting that because “the vast majority of individuals
26 who come into contact with the criminal justice system appear” before municipal courts and
27 “many of these individuals have mental illness and co-occurring substance use disorders,”
28 municipal courts may be an especially effective “and often overlooked” method of diversion of
29 individuals with mental illness from the justice system²⁶; and
30

31 Whereas, In addition to SAMHSA and BJA, several nonprofit advocacy organizations, including
32 Mental Health America, the National Alliance on Mental Illness, the Treatment Advocacy Center,
33 the National Sheriffs’ Association, the Council on State Governments, and the National Center
34 for State Courts, support the use of mental health courts^{2,27-32}; and
35

36 Whereas, While several hundred mental health courts exist across all 50 states, mental health
37 courts do not exist in all counties and localities, indicating that these programs may not be
38 accessible or available to all individuals who could benefit from them⁴; and

1 Whereas, Because mental health courts are dependent on participation from national, state, and
2 local governmental agencies, justice systems, and mental health service organizations and on
3 the appropriation of public funds, including federal monies for MIOTCRA programs and grants
4 administered by SAMHSA and BJA¹⁰⁻¹², the AMA can play a role in advocating for the continued
5 support and funding of mental health courts by policymakers; and
6

7 Whereas, Courts that connect individuals with mental illness to treatment as an alternative to
8 incarceration exist under many different names, with each focused on different types of mental
9 illness, including “mental health courts” (for mental illness in general), “drug courts” (for
10 substance use disorders), and “sobriety” or “sober courts” (for alcohol use disorder and
11 sometimes certain other substance use disorders)³²⁻³⁵; and AMA policy should be inclusive of all
12 these different types; and
13

14 Whereas, At I-19, a similar version of this resolution was adopted by our AMA-MSS as Policy
15 345.021MSS, establishing support for “mental health courts, including drug courts and sober
16 courts...for individuals with mental illness and substance use disorders who are convicted of
17 nonviolent crimes”; and
18

19 Whereas, Existing AMA Policy H-100.955 (passed at A-12) established support for drug courts,
20 which are similar in function to mental health courts but narrower in scope, “for individuals with
21 addictive disease who are convicted of nonviolent crimes”; and
22

23 Whereas, Existing AMA Policy H-510.979 (passed at I-19) established support for veteran
24 courts, which are similar in function to mental health courts but narrower in scope, “for veterans
25 who commit criminal offenses that may be related to a neurological or psychiatric disorder”; and
26

27 Whereas, At I-19, HOD Reference Committee B originally recommended amending Resolution
28 202 on veteran courts to limit their use to only nonviolent offenses, to be consistent with
29 previous Policy H-100.955 on drug courts³⁶⁻³⁷; and
30

31 Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was
32 extracted in our HOD to remove the restriction on only using veteran courts for nonviolent
33 offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could
34 potentially be used for criminal offenses in general and not only for nonviolent offenses³⁶; and
35

36 Whereas, To be consistent with our HOD’s most recent debate on this matter, Policy H-100.955
37 on drug courts and any future AMA policy on alternatives to incarceration for individuals with
38 mental illness should not be limited to only nonviolent offenses; therefore be it
39

40 RESOLVED, That American Medical Association Policy H-100.955, Support for Drug Courts, be
41 amended by addition and deletion to read as follows:
42

43 Support for Mental Health Drug Courts, H-100.955

44 Our AMA: (1) supports the establishment and use of mental health drug courts, including
45 drug courts and sobriety courts, as an effective method of intervention for individuals
46 with mental illness involved in the justice system within a comprehensive system of
47 community-based services and supports; (2) encourages legislators to establish mental
48 health drug courts at the state and local level in the United States; and (3) encourages
49 mental health drug courts to rely upon evidence-based models of care for those who the
50 judge or court determine would benefit from intervention rather than incarceration.

51 (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution seeks to amend current AMA policy supporting the use of drug courts in a more expansive manner toward support of “mental health courts.” These are special courts comprised of judges, prosecutors, defense attorneys, and other personnel with expertise in mental health designed to rehabilitate persons with mental illness and decrease the percentage of persons with mental illness incarcerated without the appropriate treatment. Mental health courts have been shown to decrease recidivism, risk of violence, and re-hospitalization among individuals with mental illness in the justice system. Our delegation prioritizes behavioral health equity and parity. This resolution would ensure that individuals with mental illness involved in the justice system are connected to mental health services and are not unjustly incarcerated or oppressed due to a treatable and manageable illness.

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RELEVANT AMA POLICY

Support for Drug Courts H-100.955

Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

Res. 201, A-12; Appended: BOT Rep. 09, I-19

Support for Veterans Courts H-510.979

Our AMA supports the 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.

Res. 202, I-19

Maintaining Mental Health Services by States H-345.975

Our AMA:

1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.

Res. 116, A-12; Reaffirmation A-15

Support for Justice Reinvestment Initiatives, H-95.931

Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.

Res. 205, A-16

Prevention of Impaired Driving H-30.936 (excerpted)

Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life; CCB/CLRPD Rep. 3, A-14

Court-Initiated Medical Treatment in Criminal Cases, E-9.7.2

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments.

Individual physicians who provide care under court order should:

(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.

(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.

(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.

(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

AMA Principles of Medical Ethics: I,III (Code of Medical Ethics Opinion, Issued: 2016

Decisions for Adult Patients Who Lack Capacity, E-2.1.2

Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:

- (a) Identify an appropriate surrogate to make decisions on the patient's behalf:
 - (i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
 - (ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
- (b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
- (c) Provide advice, guidance, and support to the surrogate.
- (d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
 - (i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
 - (ii) the patient's views about life and how it should be lived;
 - (iii) how the patient constructed his or her life story; and
 - (iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
- (e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
 - (i) the pain and suffering associated with the intervention;
 - (ii) the degree of and potential for benefit;
 - (iii) impairments that may result from the intervention;
 - (iv) quality of life as experienced by the patient.
- (f) Consult an ethics committee or other institutional resource when:
 - (i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
 - (ii) ongoing disagreement about a treatment decision cannot be resolved; or
 - (iii) the physician judges that the surrogate's decision:
 - a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
 - b. could not reasonably be judged to be in the patient's best interest; or
 - c. primarily serves the interests of the surrogate or other third party rather than the patient.

AMA Principles of Medical Ethics: I,III,VIII (Code of Medical Ethics Opinion, Issued: 2016)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(JUN-21)

Introduced by: Medical Student Section

Subject: Advocating for the Amendment of Chronic Nuisance Ordinances

Referred to: Reference Committee B

1 Whereas, Chronic nuisance ordinances (CNOs) are municipal laws that aim to lower the crime
2 rate taking place on rental properties by penalizing property owners if repeated incidents of
3 nuisance activity occur over a set period of time (typically, 12 months)¹; and
4

5 Whereas, CNOs are part of a phenomenon called “third-party policing,” through which cities
6 require private citizens – in this case property owners – to address criminal or otherwise
7 undesirable behaviors¹; and
8

9 Whereas, Punishments for violating CNO’s may range from warning letters and fines to
10 evictions and building closures, and often involve a “nuisance point system” where a certain
11 number of accumulated points will result in eviction and other actions¹; and
12

13 Whereas, What qualifies as nuisance activity can vary widely between municipalities, though
14 commonly defined as the amount of contact with emergency services, first responders, and
15 police, for criminal behavior that occurs on or near the property, or “alleged nuisance conduct”
16 (assault, harassment, stalking, disorderly conduct, city code violations, noise violations, and
17 others)²; and
18

19 Whereas, CNO’s have been enacted by an estimated 2,000 municipalities across 44 states as
20 of 2014 ³; and
21

22 Whereas, Nuisance ordinances often apply even when a resident was the victim, and not the
23 source, of the nuisance activity^{3,17}; and
24

25 Whereas, CNOs punish tenants who require police and emergency medical assistance by
26 making eviction a consequence of police responses to their homes¹; and
27

28 Whereas, The reason for calling the police is not taken into account by most CNOs, so people
29 who experience mental health crises may be deemed perpetrators of nuisance activity for
30 seeking emergency medical assistance at a frequency beyond the threshold established in the
31 CNO and may be threatened with eviction by their landlords¹; and
32

33 Whereas, Cities have fined group homes (organizations that provide community-based
34 residences for people with disabilities) after staff sought police or emergency services
35 assistance responding to their residents’ medical emergencies¹⁵; and
36

37 Whereas, Health crises that can count as a CNO violation include drug overdoses: public
38 records from a sample of Northeast Ohio cities found that 10-40% of applications of CNOs are
39 related to a person experiencing a drug overdose, many of which explicitly include violations of
40 criminal drug abuse laws as nuisance¹⁵; and

1 Whereas, CNO nuisance behavior can include the aesthetic appearance of property, such as
2 litter, an un-mowed lawn, or an “unsightly” yard, which can be applied against residents whose
3 physical, mental, or health-related disabilities prevent them from meeting their municipality’s
4 maintenance standards¹; and

5
6 Whereas, In June 2017, an appellate court struck down the Village of Groton’s nuisance law as
7 unconstitutional under the First Amendment, the reasoning being that it deterred tenants from
8 seeking police assistance, and discouraged people, including domestic violence victims, from
9 reaching out for help⁴; and

10
11 Whereas, Surveys of nuisance ordinance enforcement from across the country suggest that
12 chronic nuisance ordinances disproportionately impact people of color²; and

13
14 Whereas, Between 2012 and 2018, the city of Rochester, NY issued nearly five times as many
15 nuisance enforcement actions in the quarter of the city with the highest concentration of people
16 of color as it did in the quarter with the lowest concentration of people of color²; and

17
18 Whereas, A lawsuit filed in August 2017 by a fair housing organization in Peoria, Illinois
19 revealed that properties in predominantly black neighborhoods were more than twice as likely to
20 be cited under the city’s nuisance ordinance as white neighborhoods⁵; and

21
22 Whereas, A two-year study of Milwaukee, Wisconsin found that properties in predominantly
23 black neighborhoods were over two and a half times as likely to receive a nuisance citation as
24 properties in predominantly white neighborhoods, even when the neighborhoods made similar
25 numbers of calls⁶; and

26
27 Whereas, Women with disabilities have a 40% greater chance of experiencing domestic
28 violence than women without disabilities⁸; and

29
30 Whereas, There are an estimated 1.3 million women who are the victims of assault by an
31 intimate partner annually, and women have a 25% lifetime risk of intimate partner violence⁷; and

32
33 Whereas, Congress acknowledges that “women and families across the country are being
34 discriminated against, denied access to, and even evicted from public and subsidized housing
35 because of their status as victims of domestic violence”⁷; and

36
37 Whereas, Domestic violence advocates’ efforts in the past decades have been focused on
38 educating law enforcement on how to approach and aid victims in escaping the cycle of
39 domestic violence while maintaining their housing³; and

40
41 Whereas, This initiative is directly being threatened by CNOs, as calls about domestic
42 disturbances can result in the eviction of everyone in the household^{3,10-13}; and

43
44 Whereas, Nuisance ordinances frequently fail to make exceptions for police calls made by
45 residents experiencing domestic violence even in cases where exceptions exist, calls placed by
46 survivors of domestic violence are regularly miscategorized and the tenants are punished under
47 the CNO regardless⁹; and

48
49 Whereas, Such punishment of domestic violence-related calls for police and medical services
50 discourages victims of domestic violence from seeking help in future assaults¹⁰; and

1 Whereas, The use of CNOs may contribute to the “double victimization” of domestic violence
2 victims, who may be evicted because of allegations of disturbing other tenants or property
3 damage caused by their abusers, and thus are more likely to hide the abuse rather than seek
4 help like emergency services¹¹; and

5
6 Whereas, The data on whether CNOs are effective at accomplishing their goals of reducing
7 nuisance activity is limited^{6,9,12}; and

8
9 Whereas, Even though Cincinnati reported an overall 22% decrease in nuisance calls from
10 2006-2010, it is unknown whether this drop is due to underreporting or actual decreases in such
11 behavior¹²; and

12
13 Whereas, Housing instability and eviction is associated with a higher risk of depression, anxiety,
14 and even suicide^{14,18}; and

15
16 Whereas, Individuals who lost legal rights to their housing and whose landlords applied for
17 eviction proceedings were four times more likely to commit suicide (OR = 4.42) compared to
18 individuals who had not experienced eviction¹⁶; and

19
20 Whereas, The disproportionate impact of CNOs on people of color, with disabilities, and/or
21 victims of domestic violence limit the opportunities for these tenants to find affordable housing in
22 the future, regardless of the circumstances in which they occurred¹³; therefore be it

23
24 RESOLVED, That our American Medical Association advocate for amendments to chronic
25 nuisance ordinances that ensure calls made for safety or emergency services, are not counted
26 towards nuisance designations (Directive to Take Action); and be it further

27
28 RESOLVED, That our AMA support initiatives to (a) gather data on chronic nuisance ordinance
29 enforcement and (b) make that data publicly available to enable easier identification of
30 disparities. (New HOD Policy)

31
Fiscal Note: Minimal - less than \$1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution seeks to advocate for changes in procedure to Chronic Nuisance Ordinances (CNOs) and to support initiatives that increase the data available on CNOs. Cities across 44 states in the US have enacted Chronic Nuisance Ordinances (CNOs), which are municipal laws that penalize landowners and tenants when emergency services or law enforcement are called frequently to the premises. Importantly, CNOs in many municipalities do not distinguish between victims and perpetrators of nuisance activities. Numerous health crises can count as a CNO violation including drug overdoses, domestic or partner violence, and even mental health crises. As a consequence, tenants who require frequent police or emergency medical assistance may face threats of eviction and encounter discrimination when applying to housing. Thus, the enforcement of CNOs can penalize callers to the police and emergency services for assistance regardless of the situational context. CNOs are a serious detriment to our mission as physicians to “do no harm”. Our AMA should advocate for the amendment of CNOs to ensure that residents are not reprimanded in situations where they are victims.

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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- (6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
- (7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- (8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- (9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
- (10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(JUN-21)

Introduced by: Medical Student Section

Subject: Supporting Collection of Data on Medical Repatriation

Referred to: Reference Committee B

- 1 Whereas, Forced medical repatriation is the involuntary return of civilians in need of medical
2 treatment to their country of origin by healthcare professionals¹; and
3
- 4 Whereas, Forced medical repatriation results in an involuntary transfer of a patient to a foreign
5 country, provoking an unwarranted intersection between immigration enforcement and the
6 healthcare system²; and
7
- 8 Whereas, Of the estimated 10.5 million undocumented immigrants in the United States in 2017,
9 a study found expenditures on immigrants in 2016 accounted for less than 10% of the overall
10 healthcare spending in a population with the highest risk of being uninsured among the non-
11 elderly population²⁻⁴; and
12
- 13 Whereas, Under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), federally
14 funded health institutions with emergency care capabilities are mandated to treat all patients
15 with emergent medical conditions who present to their facility until deemed stable, regardless of
16 their insurance coverage or financial status⁵; and
17
- 18 Whereas, Once deemed stable, medical centers must consider medical repatriation if no long-
19 term care alternative is available to the patient as a cost-saving mechanism⁶; and
20
- 21 Whereas, Care centers like St. Joseph's Hospital and Medical Center in Phoenix, Arizona
22 partake in forced medical repatriation for undocumented immigrant patients and a Florida
23 patient experienced involuntary deportation prior to the completion of their appeal or asylum
24 verdict⁷⁻⁹; and
25
- 26 Whereas, Forced medical repatriation has led to serious medical consequences for patients,
27 including the exacerbation of existing medical conditions^{10,11}; and
28
- 29 Whereas, Patients experienced a lapse and deterioration of care due to the inability of the
30 patient's country of origin to provide adequate treatment and concurrent separation from their
31 community in the U.S. during a time which may require emotional, physical and financial
32 support^{6,7,9,12}; and
33
- 34 Whereas, Hospitals fail to inform patients, or their guardians of potential adverse medical
35 consequences related to repatriation^{7,13}; and
36
- 37 Whereas, Forced medical repatriation increases health disparities among migrant communities
38 and deters immigrants from seeking necessary medical services^{14,15}; and

1 Whereas, Forced medical repatriation often violates the Centers for Medicare and Medicaid
2 Services' Conditions of Participation regulation which commits hospitals to ensure patients have
3 the right to conduct informed decisions regarding their care^{16,17}; and
4

5 Whereas, Forced medical repatriation violates the patient's constitutional right to due process,
6 especially if the patient is able to claim asylum¹⁸; and
7

8 Whereas, The AMA *Journal of Ethics* encourages health care systems to seek routes of care to
9 avoid forced medical repatriation and the AMA Code of Ethics Opinion 1.1.8 states that
10 "physicians should resist any discharge requests that are likely to compromise a patient's
11 safety" and that the "discharge plan should be developed without regard to socioeconomic
12 status, immigration status, or other clinically irrelevant considerations"^{2,19,20}; and
13

14 Whereas, The AMA is pursuing policy focused on alternative routes for immigrant healthcare
15 through Health Care Payment for Undocumented Persons (D-440.985) and Federal Funding for
16 Safety Net Care for Undocumented Aliens (H-160.956)^{21,22}; and
17

18 Whereas, Data on repatriation of civilians is not reported through any government agency or
19 otherwise, and there is a lack of documentation^{7,23}; therefore be it
20

21 RESOLVED, That our American Medical Association ask the Department of Health and Human
22 Services to collect and de-identify any and all instances of medical repatriations from the United
23 States to other countries by medical centers to further identify the harms of this practice
24 (Directive to Take Action); and be it further
25

26 RESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD
27 Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The resolution denouncing the practice of forced repatriations in accordance to our ethical standards addressed a unique problem and proposes a change to existing policy. It clearly addresses an important ethical dilemma and public health crisis as a result of forced medical repatriations on our vulnerable immigrant communities and seeks to address forced medical repatriation by proposing an amendment to H-350.957. Currently, there is no mention of medical repatriation in existing AMA policies and under the current political climate revolving immigrant health, we feel that this obviously unethical practice urgently needs to be researched and denounced by our AMA. We believe that this is the natural progression of our nation's medical society towards caring for one of our most disenfranchised members of society.

By advocating for data collection and documentation of repatriation cases, this resolution also demands transparency into an issue that has been rendered invisible due to a lack of data. We believe that this resolution represents a timely and positive step forward during a time in which immigrant health has come under threat.

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RELEVANT AMA POLICY

Limit Scope of EMTALA to Original Legislative Intent D-130.994

(1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians; (b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients; (c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and (d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement.

(2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the

discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose.

(3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting. (Sub. Res. 217, I-00, Reaffirmed: BOT Rep. 6, A-10)

EMTALA -- Major Regulatory and Legislative Developments D-130.982

Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply. (BOT Rep. 17, I-02, Reaffirmation: A-07, Modified: BOT Rep. 22, A-17)

Access to Emergency Services H-130.970

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care. (CMS Rep. A, A-89, Modified: CMS Rep. 6, I-95, Reaffirmation: A-97, Reaffirmed: Sub. Res. 707, A-98, Reaffirmed: Res. 705, A-99, Reaffirmed: CMS Rep. 3, I-99, Reaffirmation: A-00, Reaffirmed: Sub. Res. 706, I-00, Amended: Res. 229, A-01, Reaffirmation and Reaffirmed: Res. 708, A-02, Reaffirmed: CMS Rep. 4, A-12, Reaffirmed: CMS Rep. 07, A-16, Appended: Res. 128, A-17, Reaffirmation: A-18, Reaffirmed in lieu of: Res. 807, I-18)

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950

Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act ((EMTALA)) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under (EMTALA); (2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act ((EMTALA)) rules and regulations; (3) urgently seeks return to the original congressional intent of (EMTALA) to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous (EMTALA) requirements. (Sub. Res. 214, A-97, Reaffirmation: I-98, Reaffirmation: A-99, Appended: Sub. Res. 235 and Reaffirmation A-00, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17)

Emergency Transfer Responsibilities H-130.957

Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to: (1) require that the Office of the Inspector General (IG) request and receive the review of the Peer Review Organization (PRO) prior to imposing sanctions; (2) make the PRO determination in alleged patient transfer violations binding upon the IG; (3) expand the scope of PRO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks; (4) restore the knowing standard of proof for physician violation; (5) recognize appropriate referral of patients from emergency departments to physician offices; (6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer; (7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient; (8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and (9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act. (Sub. Res. 78, A-91, Reaffirmation: A-00, Reaffirmed: BOT Rep. 6, A-10)

Repeal of COBRA Anti-Physician Provisions H-130.959

It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility. (Sub. Res. 145, I-90, Reaffirmed: Sunset Report, I-00, Reaffirmed: BOT Rep. 6, A-10)

Health Care Payment for Undocumented Persons D-440.985

Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level. (Res. 148, A-02, Reaffirmation: A-07, Reaffirmed: CMS Rep. 1, A-17, Reaffirmation: A-19)

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents. (Res. 920, I-06, Reaffirmed and Appended: Res. 140, A-07, Modified: CCB/CLRPD, Rep. 2, A-14)

Federal Funding for Safety Net Care for Undocumented Aliens H-160.956

Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens. (Sub. Res. 207, A-93, Reaffirmed: BOT Rep. 17, I-94, Reaffirmed: Ref Com B, A-96, Reaffirmation: A-02, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Reaffirmation: A-19)

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921

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. (Res. 232, I-17)

Addressing Immigrant Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin. (Res. 804, I-09, Appended: Res. 409, A-15, Reaffirmation: A-19, Appended: Res. 423, A-19)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(JUN-21)

Introduced by: Medical Student Section

Subject: Using X-Ray and Dental Records for Assessing Immigrant Age

Referred to: Reference Committee B

- 1 Whereas, Skeletal and dental maturity are assessed from hand-wrist radiographs and dental x-
2 rays, which together are compared to growth charts to determine the age of an individual¹; and
3
4 Whereas, Estimated chronological age determined from growth charts, hand-wrist radiographs,
5 and dental X-rays may not correlate with the true chronological age of an individual due to
6 population and geography-specific factors, including nutritional intake, environmental exposure,
7 and genetics to such an extent that the Centers for Disease Control (CDC) recommends against
8 using hand-wrist radiographs to determine the age of refugees¹⁻⁵; and
9
10 Whereas, International records highlight the wide variety in growth charts utilized country to
11 country, in part due to different genetics, nutrition, medical conditions, and environmental
12 exposures^{6,7,8}; and
13
14 Whereas, The Department of Homeland Security (DHS) and the Department of Health and
15 Human Services (HHS) will request new skeletal and dental x-ray imaging to establish the age
16 of an individual crossing the border⁹; and
17
18 Whereas, According to Food and Drug Administration recommendations, performing x-rays on
19 children comes with greater risk of radiation-related illness and should only be used to answer a
20 clinical question or to guide treatment¹⁰; and
21
22 Whereas, The DHS handbook, in collaboration with the Office of Refugee Resettlement , which
23 is part of HHS, states that medical images may be used only when no other means of verifying
24 chronological age exist^{9,11}; and
25
26 Whereas, The DHS handbook states that acceptable documentation to verify chronological age
27 can include official government-issued documents such as a birth certificate, other
28 governmental records, a baptismal certificate, school records, medical records, or other
29 objective documentation with a date of birth listed⁹; and
30
31 Whereas, If the immigrant/refugee does not have their birth certificate, the DHS handbook
32 states that affirmative steps should be taken to contact the refugee's home country's relevant
33 record keeping department to verify their birth date⁹; and
34
35 Whereas, The DHS handbook directs immigration officers to accept statements by the person in
36 question, their family members, other people who know the person as verifying evidence⁹; and
37
38 Whereas, As part of the 2009 Appropriations Bill, Congress stated its concern that Immigration
39 and Customs Enforcement (ICE) had not stopped using fallible bone and dental forensics for

1 child age determination and has since decreased their use of age determination exams ^{12,13};
2 and
3

4 Whereas, In 2018, ICE decreased the number of age determination exams it used to less than
5 50; meanwhile, HHS increased its utilization of the exams for those in the care of the ORR to
6 almost 700 , almost double the number granted to both agencies in each of the prior two
7 years¹³; and
8

9 Whereas, Minors who are incorrectly classified as adults due to dental and x-ray imaging are
10 held in adult detention centers while waiting for their cases to be heard and therefore are not
11 held in the least restrictive setting, in violation of the federal government's promise to do so in
12 the Flores Agreement and further restricting their rights ¹⁴; and
13

14 Whereas, Attorneys representing minors report that their clients' supporting documentation was
15 not used and were instead placed in adult detention centers solely based on x-ray images for
16 months until federal judges ruled that ICE and HHS could not classify their immigrant clients as
17 adults based solely on imaging¹⁵; and
18

19 Whereas, As an example, one 19-year-old woman immigrating to the U.S. on a fiancée visa was
20 incorrectly deemed a minor based on dental and hand-wrist radiographs and was not released
21 to her aunt, resulting in her involuntary detainment in a shelter for minors for 14 months¹⁶; and
22

23 Whereas, Existing AMA policy H-65.958 states that the AMA will advocate for the healthcare
24 services provided to minor immigrants, both in detention and those held at border patrol
25 stations; and
26

27 Whereas, Existing AMA policy H-315.966 states that the AMA supports protections that prohibit
28 U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law
29 enforcement agencies from utilizing information from medical records to pursue immigration
30 enforcement actions against patients who are undocumented; therefore be it
31

32 RESOLVED, That our American Medical Association support discontinuation of the use of non-
33 medically necessary dental and bone forensics to assess an immigrant's age. (New HOD
34 Policy)

Fiscal Note: Minimal - less than \$1,000

Date Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

Our delegation prioritizes protections towards vulnerable and marginalized members in our society, including immigrants and refugees. This resolution addresses the inappropriate use of dental and bone X-rays in determining immigrant person's age. This resolution contains data suggesting bone and dental forensics are inadequate measures for determining age in immigrants crossing the US border who have other documentation, and the harm this practice causes. Not only can the unnecessary use of medical imaging increase radiation exposure to children but this technology has also been shown to be an imprecise and inaccurate method of age determination. There are current reports of minors being held in adult detention camps due to ICE policy that encourages the use of X Rays and dental records over self-reported or even documented age. We believe that this resolution represents a novel, and timely action taken on behalf of an incredibly vulnerable population and thus ask the House's consideration.

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RELEVANT AMA POLICY

Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court H-65.958

Our AMA will: (1) advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely on the health and well-being of the children; and (2) condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent. (Res. 013, A-19)

HIV, Immigration, and Travel Restrictions H-20.901

Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non-immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose. (CSA Rep. 4, A-03 Modified: Res. 2, I-10 Modified: Res. 254, A-18)

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. (Res. 018, A-17)