

Instruction Sheet

For the Virtual House of Delegates and Reference Committee Hearings

This instruction sheet is provided to assist participants with navigating the virtual House of Delegates and Reference Committee Hearings. Information such as understanding how to use and log into platforms, how to join the speaking queue and what to do if you are having technical problems are included. We advise reading this prior to attendance at the House of Delegates and Reference Committee Hearings. Keep it available during the virtual meeting for reference as well.

Your Two Platforms

You will use two platforms to participate in the House of Delegates and Reference Committees:

1. Lumi Platform	2. Zoom Webinar
<p>Use for:</p> <ul style="list-style-type: none"> • Entering the speaking queue. (A key to the speaking Action Terms you must use will be found in the Lumi platform). • Voting on elections and motions. • Viewing documents. 	<p>Use for:</p> <ul style="list-style-type: none"> • Viewing meeting proceedings. • Raising your hand to speak when asked to do so by the presiding officer. • Enabling your camera • Enabling your microphone, after being called on by the presiding officer.

You will have **both** the Lumi Platform and Zoom Webinar open on your computer in two different windows. You may use two devices. For example, a separate mobile or tablet may be used to log into the Lumi platform to request to speak and vote.

Your Login Instructions

- For the **LUMI** Platform: click on the provided Lumi link (page 2) for the respective session.
 - Delegate Credentials = 9-character alphanumeric codes mailed and emailed to you. (NOTE: A unique Election Credential will begin with "E" and will be solely for the ELECTIONS SESSION on Tuesday morning, June 15, 9am-10am).
 - **Business Credential:** Letter B followed by 8 digits, e.g. B12345678, with password *2021special* (lowercase)
 - **Election Credential:** Letter E followed by 8 digits, e.g. E12345678, with password *elect2021a* (note the "a" suffix)
 - Alternates and members wishing to speak during reference committee hearings should simply login as "guests"
- For **ZOOM**: click on the provided Zoom Webinar link (page 2) for the respective session and **use your first and last name at login**. Please ensure you have entered the same first and last name as in LUMI.
- Reminder to **Alternate Delegates** (only when "seated" in the HOD) you will use your delegates Business Credential but must still enter your first and last name in ZOOM.

Your Links

LUMI Links

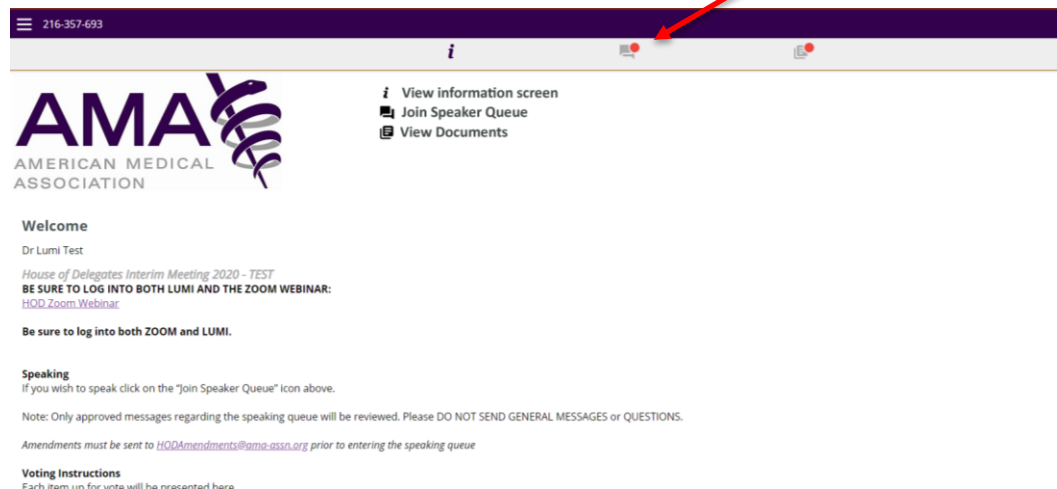
	Lumi Link
House of Delegates:	https://web.lumiagm.com/216357693
<i>House of Delegates ELECTIONS SESSION:</i>	https://web.lumiagm.com/255696255
Reference Committees:	
Reference Committee on Amends to Constitution & Bylaws	https://web.lumiagm.com/241735929
Ref. Comm. A: Medical Service	https://web.lumiagm.com/274090432
Ref. Comm. B: Legislation	https://web.lumiagm.com/275733334
Ref. Comm. C: Medical Education	https://web.lumiagm.com/237093468
Ref. Comm. D: Public Health	https://web.lumiagm.com/224476920
Ref. Comm. E: Science and Technology	https://web.lumiagm.com/251204813
Ref. Comm. F: Finance	https://web.lumiagm.com/287459516
Ref. Comm. G: Medical Practice	https://web.lumiagm.com/228849913

Zoom Links

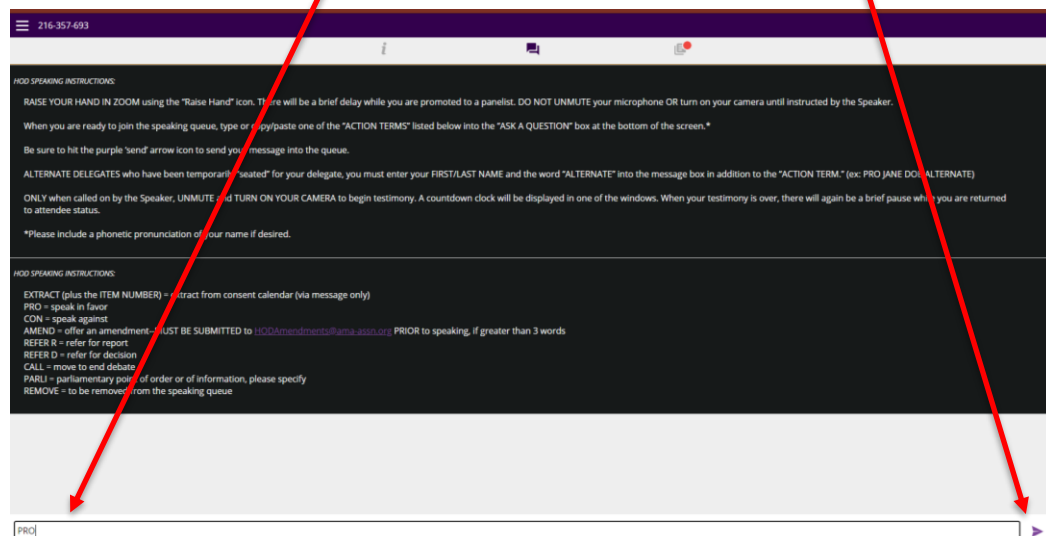
	Zoom details	Zoom Passcode
House of Delegates (also use for ELECTIONS SESSION):	https://lumiglobal.zoom.us/j/95914188733?pwd=RnJrWk5CWG5Wb2dDTEpHRmprL2plUT09	025622
Reference Committees:		
Reference Committee on Amends to Constitution & Bylaws	https://lumiglobal.zoom.us/j/99033965956?pwd=bWN3a1h3RXEwdGluT3RMcVQUW5Bdz09	938682
Ref. Comm. A: Medical Service	https://lumiglobal.zoom.us/j/97462036233?pwd=dEQrS2Z5bmx6eWd5em8wUjlzeTRsZz09	808953
Ref. Comm. B: Legislation	https://lumiglobal.zoom.us/j/99647757847?pwd=ZE15YWJ4U2c5S1ZqZnNBK1RjVUJwdz09	837837
Ref. Comm. C: Medical Education	https://lumiglobal.zoom.us/j/93229170874?pwd=c1lweTJOeSs4N1NBbW5tUIQzS3d6dz09	227082
Ref. Comm. D: Public Health	https://lumiglobal.zoom.us/j/99380134139?pwd=ZVVObS9XcGRIRzhOa1d4dUVJU3lvZz09	651394
Ref. Comm. E: Science and Technology	https://lumiglobal.zoom.us/j/92874187312?pwd=Ym05LzhBZk5PdKxhT1ltZCtabDdEdz09	662974
Ref. Comm. F: Finance	https://lumiglobal.zoom.us/j/94360506466?pwd=ZytaUkh4N2luQSt5dkl4T2lDNWtZUT09	545659
Ref. Comm. G: Medical Practice	https://lumiglobal.zoom.us/j/94965135046?pwd=Tmc2MlNBW5a5S1pTYjk2M3FacVhYZz09	988373

Speaking during the virtual meeting

- When you log into the LUMI Platform, you will see the Information Screen.
- Once the Speaker opens the Speaking Queue, you can click the 'Join Speaker Queue' icon in the menu bar.

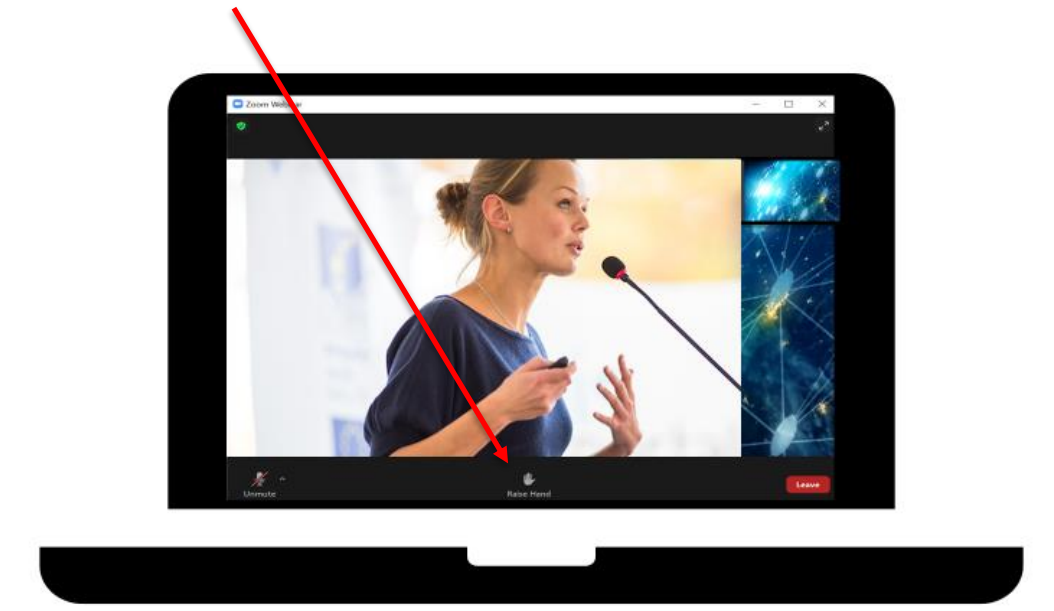


- To join the speaking queue, you MUST enter (copy/paste or type) one of the listed **Action Terms** in the "Ask a Question" box at the bottom and hit the 'purple' arrow icon.

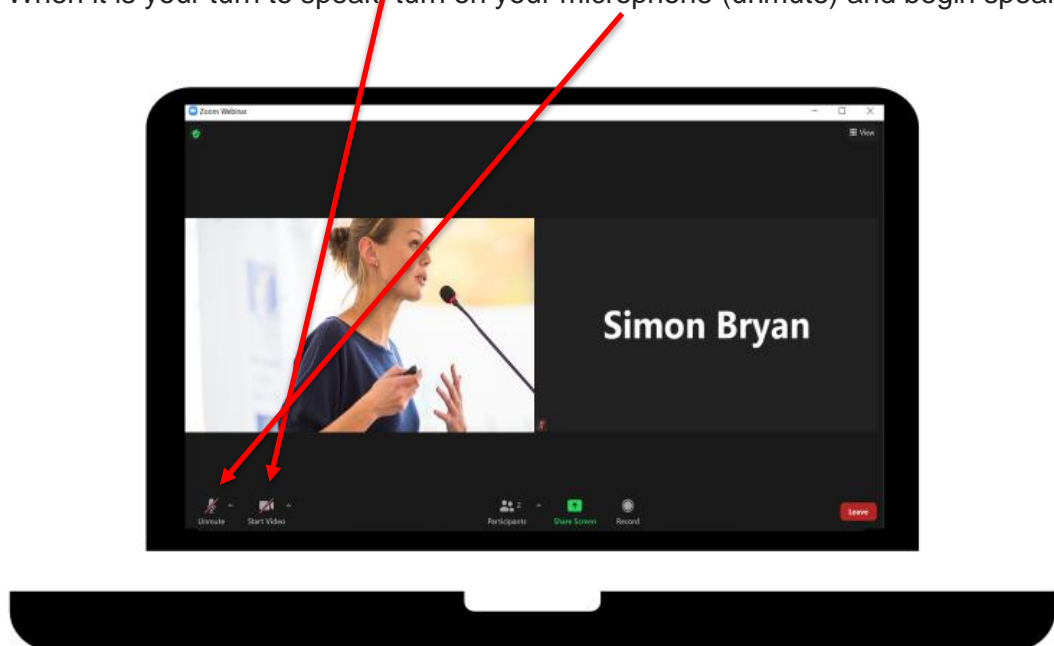


- **DO NOT ENTER ANY OTHER COMMENTS OR QUESTIONS INTO THE BOX.**
- ALTERNATE DELEGATES FOR THE HOD ONLY-After your Action Term add your FIRST and LAST NAME and ALTERNATE (ex PRO JANE DOE ALTERNATE)

- The presiding officer will announce the order of speakers. When your name is announced, **RAISE YOUR HAND IN THE ZOOM PLATFORM.**



- There will be a slight pause as you are moved from an "Attendee" in ZOOM to a "Panelist." **Turn on your camera but DO NOT unmute until directed to do so by the presiding officer.**
- When it is your turn to speak, turn on your microphone (unmute) and begin speaking.

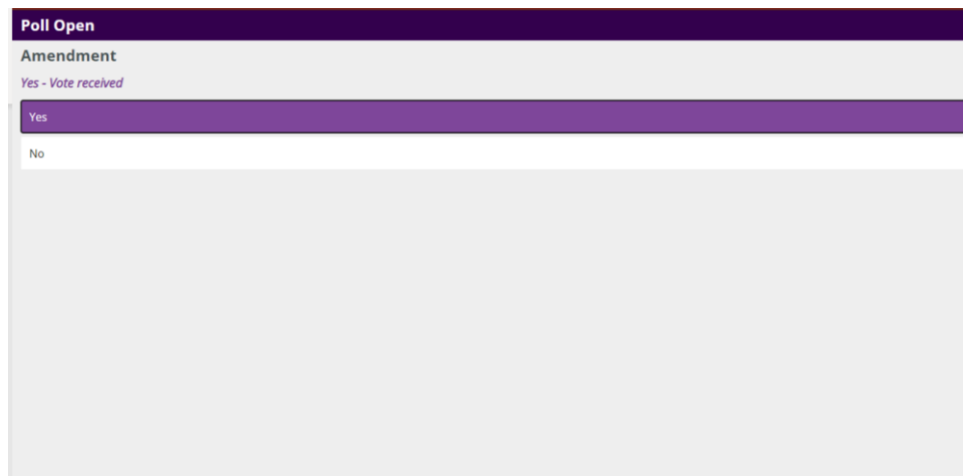


- You will see a countdown timer in one of the windows showing your allotted time (90 seconds-unless changed by the presiding officer).

- Once your turn to speak is over, the production team will mute your microphone and disable your camera, moving you back to an 'Attendee' (again there will be a slight pause as you switch back).

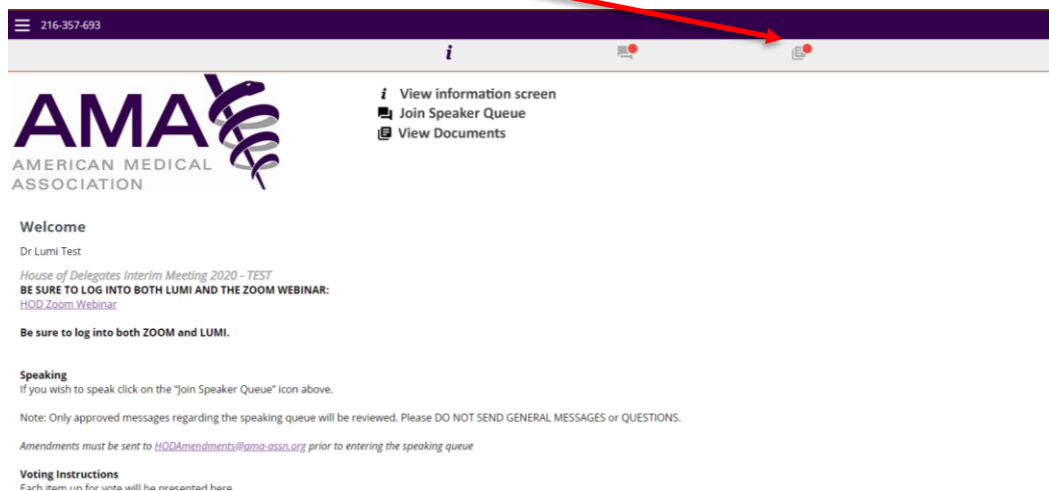
Voting

- Voting items will appear automatically in the Lumi platform.
- When the vote appears, select YES or NO, your vote will be cast automatically. If you wish to change your vote, you may do so as long as the poll is open. Remember only your last selection will be counted.



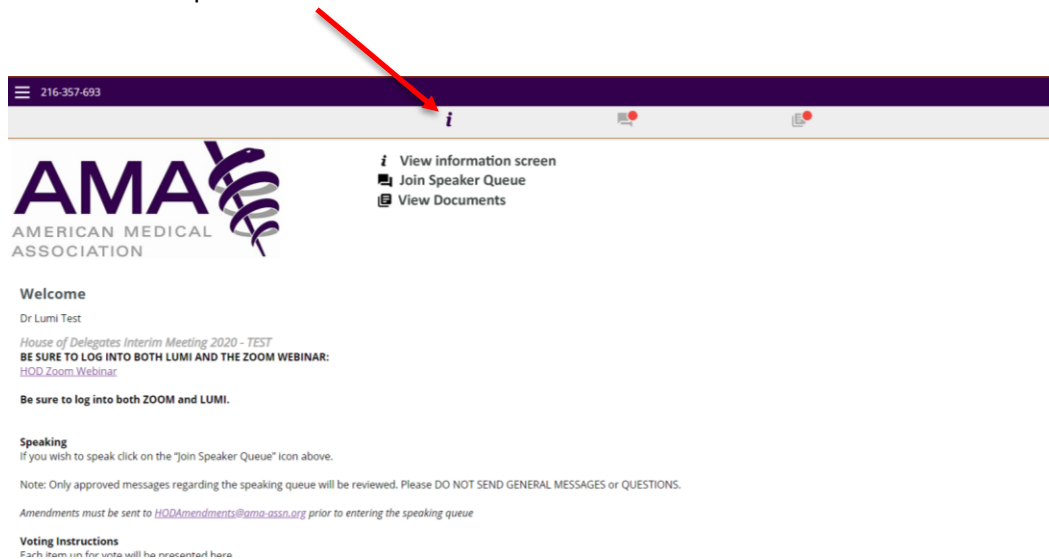
Viewing Documents

- You can view meeting documents by clicking on the Documents icon in the menu bar in the Lumi platform.



Information Screen

- You may return to the information screen by clicking on the Information icon on the menu bar in the Lumi platform.



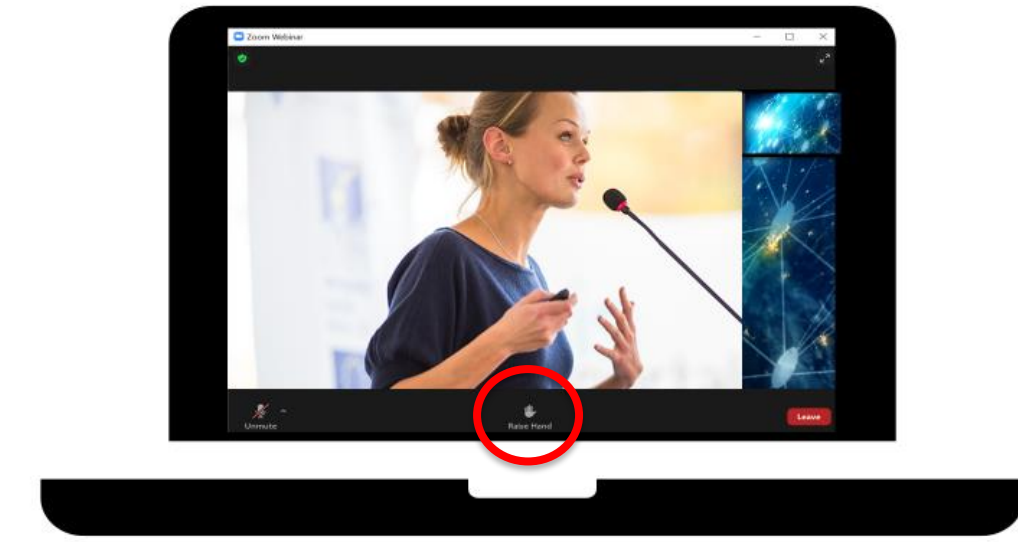
Best Practice Tips

The following are tips to prepare for the best virtual meeting experience:

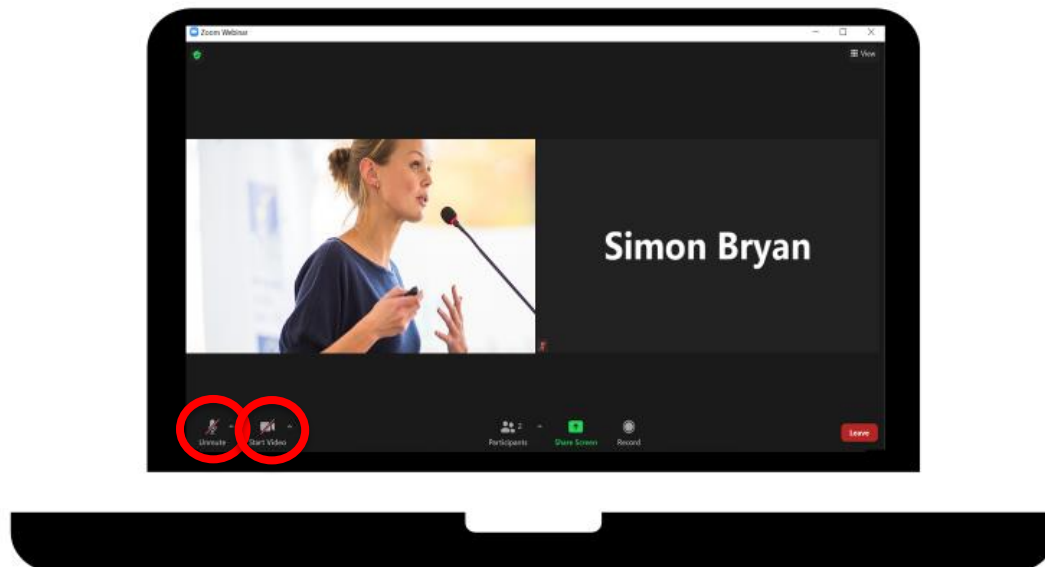
- If possible, connect to the Internet via an Ethernet cable. If using WiFi, ensure that you are close to your wireless router and that your connection is stable.
- Headsets are helpful for hearing audio and speaking more clearly.
- Speakers from the floor will be able to be seen on webcam while speaking, although a webcam is not necessary to participate in the Zoom Webinar. To share your webcam video, ensure you have a webcam built into your computer, or connect a free-standing one.
- We recommend using Zoom on a computer rather than a mobile device.
 - Please keep your microphone muted in Zoom until prompted.
- You can log into both Zoom Webinar and Lumi **up to 30 minutes** before, and ideally **at least 15 minutes before** each session.

- **Familiarize yourself with Zoom:**

- Make sure you **log into Zoom with your first and last name** so production staff can easily find you in the list and unmute your microphone if you will speak.
- Raise your hand icon – use when prompted.



- Turn on your camera in the bottom left corner after the brief pause in Zoom.
- Unmute ONLY when called upon to speak using the icon in the bottom left corner.



Practice Sessions

- There will be a practice session as listed below. We encourage all to participate in this session to test logging into the Zoom and the Lumi platforms and get comfortable using both.
 - Wednesday, June 9 at 7:00 p.m. (Central time)
- The Practice Session will use the same link as the meeting. Access the ZOOM webinar at <https://lumiglobal.zoom.us/j/95914188733?pwd=RnJrWk5CWG5Wb2dDEpHRmprL2plUT09> and enter your Zoom passcode: 025622
AND
On a second device or second tab use your Business Credential to login to Lumi <https://web.lumiagm.com/216357693> . Alternates should login as a guest.

Troubleshooting

- Participants with technical issues should email HODMeetingSupport@ama-assn.org (please include a phone number); we will contact you back as soon as possible to assist. For urgent issues during the meeting, the HOD Hotline: 800-337-1599, will be available for assistance. Please note that unless there is a widespread technical difficulty, proceedings will continue.

FAQs

- **What is my username to log into the Lumi platform?**
Delegates should have two alphanumeric codes: a **Business Credential** beginning with the letter “B” to be used for the reference committees and business sessions and an **Election Credential** beginning with the letter “E” for the Election Session only. These were sent by US mail on the yellow cover sheet attached to the *Speakers’ Letter* and will be emailed separately to you as well. Delegates may share their Business Credential with their alternate delegate, but only one person can be logged in with the credential at a time. The password for business sessions and reference committees is *2021special* (lower case) and with the Election Credential *elect2021a* (note lowercase “a” at end). Alternates and others may log into the Lumi platform as “guests” and simply input your first and last name.
- **Does the platform allow for participants to group chat with each other and other voting members during the virtual meeting?**
No, the chat and message functions are not enabled to allow participants to communicate with one another. Participants are responsible for determining a preferred method of communications outside of the provided Lumi platform and Zoom platform. Some options include use of free group chat platforms like Slack, group text or email chains, conference lines, or apps like GroupMe.
- **How do I vote?**
When a motion / resolution is put before the meeting, the voting will automatically pop up within your Lumi platform. Simply click on your selection to cast your vote.
- **Which browsers are supported?**
It is recommended to use the latest versions of Chrome, Firefox, Edge or Safari. Do not use Internet Explorer.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Report of Committee on Rules and Credentials

Presented by: Tripti C. Kataria, MD, Chair

June 11, 2021

1 Mister Speaker, Members of the House of Delegates: Your Committee on Rules and Credentials
2 recommends the following rules for this Special Meeting of the House of Delegates:

3
4 1. Special Meeting of the House of Delegates (HOD)

5 In accord with the official “Call for the Special Meeting” dated March 22, 2021, the AMA House of
6 Delegates will convene via a virtual platform on June 11-16, 2021, for the purpose of leadership
7 transitions that would otherwise be addressed in association with an Annual Meeting of the HOD
8 and to conduct priority business of the Association.
9

10 2. House of Delegates Security

11 Maximum security shall be maintained at all times to prevent disruptions of the House, and only
12 those individuals who have been properly credentialed shall be permitted to vote or comment.
13

14 3. Credentials

15 The registration record of the Committee on Rules and Credentials shall constitute the official roll
16 call at this Special Meeting of the House. Delegates have been issued unique Business and Election
17 Credentials for use during the virtual meeting and should guard them carefully. If a credential is
18 compromised, it should be reported immediately to HOD@ama-assn.org. Recredentialing can be
19 accomplished by notifying the HOD office electronically, in which case a new credential shall be
20 issued and the previous credential made void. Only delegates or their alternate may vote on
21 business before the House. See deadline for recredentialing for voting in elections below.
22

23 4. Business of the House of Delegates

24 The order of business as published shall be the official order of business for this Special Meeting.
25 This may be varied by the Speaker, subject to any objection sustained by the House. Under the
26 bylaws, business is restricted to that for which this Special Meeting has been called. The House of
27 Delegates will determine which resolutions meet the criteria for consideration at this Special
28 Meeting. No further business shall be entertained.
29

30 5. Privilege of the Floor

31 Delegates may request the privilege of the floor via the virtual platform. An alternate may request
32 the privilege of the floor when “seated” for his/her delegate. The Speaker may grant the privilege of
33 the floor to such persons as may be presented by the President, or Chair of the Board of Trustees, or
34 others who may expedite the business of the House, subject to objections sustained by the House.
35

36 6. Procedures of the House of Delegates

37 As per the official “Call for the Special Meeting” and per the Bylaws governing the Special
38 Meeting, discretion shall be given to the Speaker to conduct the business before the AMA House of
39 Delegates.

1 7. Limitation on Debate

2 There will be a 90-second limit on debate per presentation, subject to waiver by the presiding
3 officer for just cause, on any oral presentation.
4

5 8. No Second Required

6 To expedite consideration of motions before the House, motions shall be assumed to have a second
7 unless an objection to the assumption of a second for a specific motion is expressed.
8

9 9. Nominations and Elections

10 The House will receive nominations for President-Elect, Speaker, Vice Speaker, Trustees and
11 Council Members during the Opening Session of this Special Meeting. Credentialed delegates who
12 wish to make a nomination from the floor should do so by typing or copy/pasting the Action Term
13 “NOMINATE” followed by the nominee’s name and the position for which he/she is being
14 nominated into the “Ask a Question” box at the bottom of the “Join the Queue” page in LUMI.
15

16 Example: NOMINATE Jane Doe for Council on Medical Service.
17

18 Only credentialed delegates may make nominations from the floor, with no seconding of
19 nominations required. Any candidate to be nominated from the floor must submit a Conflict-of-
20 Interest disclosure prior to the election. Speeches will be limited to officer candidates in contested
21 elections, with no seconding speeches permitted.
22

23 After nominations are closed, any candidate in an uncontested race will be deemed elected by
24 acclamation. Elections for contested positions will occur during the Election Session scheduled for
25 9 am CDT, June 15, 2021. Only credentialed delegates may vote in the elections. Recredentialing
26 for the Election Session must occur not later than 6 pm CDT, Monday, June 14.
27

28 10. Conflict of Interest

29 Members of the House of Delegates who have a substantial financial interest in a commercial
30 enterprise, whose interest will be materially affected by a matter before the House of Delegates,
31 must publicly disclose that interest.
32

33 11. Respectful Behavior

34 Courteous and respectful dealings in all interactions with others, including delegates, AMA and
35 Federation staff, and other parties, are expected of all attendees at House of Delegates meetings.

- 1 Mister Speaker, This concludes the Report of the Committee on Rules and Credentials and we
2 recommend its adoption.

Emily Briggs, MD
American Academy of Family Physicians

Joseph Sanfrancesco, MD *
College of American Pathologists

Elisa Choi, MD
American College of Physicians

Kenath Shamir, MD *
Massachusetts

Loralie D. Ma, MD
Maryland

Tripti C. Kataria, MD, Chair
American Society of Anesthesiologists

Joshua Mammen, MD *
International College of Surgeons - US
Section

* Alternate Delegate

Notice Regarding Points of Privilege

In light of the volume of business before the House, your Speakers would like to remind you of the following section of the Bylaws:

11.1 Parliamentary Procedure. In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the then current edition of *The American Institute of Parliamentarians Standard Code of Parliamentary Procedure*.

The AIP Standard Code provides the following parameters regarding a member's right to request privilege:

A member has the right to request a decision or action by the presiding officer or by the assembly on urgent questions involving the **immediate** convenience, comfort, rights, or privileges of the assembly or [a] member. (emphasis added)

While your Speakers appreciate everyone's desire to share information, questions of personal privilege should "pertain to an individual member or a small group of members and usually relate to their rights, reputation, conduct, safety, or convenience as members of the body." (page 75) Points of privilege that do not pertain to such matters (eg, speeches, sports updates, and competitive challenges, no matter how worthy the cause) are not proper and will be ruled out of order. As has been our custom, at appropriate times, we will allow brief announcements of upcoming functions and events that occur during the meeting.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(JUN-21)

Introduced by: American Association of Physicians of Indian Origin,
New Jersey, Michigan, Virginia, Maryland

Subject: COVID-19 Crisis in India

Referred to: Reference Committee F

1 Whereas, The world has suffered from the pandemic caused by COVID-19, causing the death
2 of millions of people across the globe; and
3

4 Whereas, Many countries have been successful in bringing the infection and death rate down;
5 and
6

7 Whereas, After the initial control over the pandemic, India, the second populous country in the
8 world is experiencing a surge of COVID-19 infections and deaths with variants like B.1.617.2
9 that has overwhelmed the health system to a point where rich and poor, even doctors in the
10 frontlines are dying with lack of basic needs like oxygen; and
11

12 Whereas, The risk of another surge of COVID-19 infection with more virulent strains in the US is
13 more likely unless the pandemic is controlled in India and across the globe; and
14

15 Whereas, Physicians of Indian origin in the United States have risen to the occasion, have
16 donated and raised millions of dollars in donations, acquired oxygen concentrators, high flow
17 oxygen devices and respirators and shipped them to India; therefore be it
18

19 RESOLVED, That our American Medical Association urge the U.S. government to provide all
20 possible assistance including surplus vaccines and vaccines that have not had emergency use
21 authorization to the citizens of India and other countries in a similar situation in this humanitarian
22 crisis (New HOD Policy); and be it further
23

24 RESOLVED, That our AMA advocate for all possible assistance through WMA and WHO for
25 government and the citizens of India and other countries in a similar situation (Directive to Take
26 Action); and be it further
27

28 RESOLVED, That our AMA recognize the extraordinary efforts of many dedicated physicians
29 and ethnic organizations assisting in this humanitarian crisis. (New HOD Policy)

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

Received: 05/24/21

AUTHOR'S STATEMENT OF PRIORITY

I understand its a late submission, but please consider it high priority, as the recent sudden surge in Covid cases in India and other countries has global implications. Globally, however, the outlook is not as positive. Worldwide, since early April, new infections are being reported at the highest rates seen since the start of the pandemic -- about 700,000 per day -- based on figures from Johns Hopkins. "The current wave of COVID-19 in India is clearly a humanitarian crisis there."

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: LATE 1002
(JUN-21)

Introduced by: Louisiana

Subject: Prohibition of Racist Characterization Based on Personal Attributes

Referred to: Reference Committee on Amendments to Constitution and Bylaws

-
- 1 RESOLVED, That it is the policy of our American Medical Association that no person or group of
2 persons shall be considered or characterized as racist based on personal attributes of race,
3 color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin,
4 age, disability, or genetic information. (New HOD Policy)

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

Received: 06/04/21

AUTHOR'S STATEMENT OF PRIORITY

On June 1, 2021, Russ Kridel, MD, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023. As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians. In the past weeks, however, I have witnessed some loss of professionalism in regard to comments regarding the Strategic Plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred."

The Strategic Equity Plan contains certain broad brush statements indicting individuals based on their personal attributes rather than their attitudes and actions; for example, it endorses the following quotation: "Locating white supremacy in individuals, rather than in structures, is how the shared commitment to white ignorance preserves one's sense of self while allowing oppressive structures to persist" (p. 14).

While confronting structural racism, there is an urgent need for our AMA to commit to avoiding broad brush characterizations that impute racism to individuals based on their personal attributes, defined in this resolution as those listed by the Equal Employment Opportunity Commission.

RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20

Discrimination Against Patients by Medical Students H-295.865

Our AMA opposes the refusal by medical students to participate in the care of patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity.

Citation: (Res. 1, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: LATE 1003
(JUN-21)

Introduced by: Louisiana

Subject: Free Speech and Civil Discourse in our American Medical Association

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 RESOLVED, That it is the policy of our American Medical Association that:

2
3 Our American Medical Association unequivocally commits to truly open discourse, debate,
4 exchange of ideas, and argument;

5
6 Our American Medical Association unequivocally commits to a culture which recognizes
7 the inherent dignity and worth of all its members, which resolves that freedom of
8 expression and civility must coexist, and where those who disagree will do so without
9 enmity;

10
11 Our American Medical Association unequivocally commits to the principle that dissenting
12 and unpopular voices must be afforded the opportunity to be heard;

13
14 Our American Medical Association unequivocally commits that members of the American
15 Medical Association of different faiths, philosophies, and persuasions may speak their
16 minds and honor their deepest convictions without fear of punishment or retaliation;

17
18 Our American Medical Association unequivocally commits that the mere exposure to ideas
19 that some may find offensive is not an act of violence or hatred, nor is the expression of
20 opposition to any such ideas an act of violence or hatred;

21
22 Our American Medical Association unequivocally commits that ideological demonization of
23 opponents to block debate and to silence disagreement in the proceedings of the
24 American Medical Association is unprofessional conduct subject to appropriate disciplinary
25 action;

26
27 Our American Medical Association unequivocally commits that defamation, obscenity,
28 intimidation, threats, and incitement to violence, have no place in the proceedings of the
29 American Medical Association, and if exhibited are unprofessional conduct subject to
30 appropriate disciplinary action. (New HOD Policy)

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

Received: 06/04/21

AUTHOR'S STATEMENT OF PRIORITY

On June 1, 2021, Russ Kridel, MD, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to the *AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023*. As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians. In the past weeks, however, I have witnessed some loss of professionalism in regard to comments regarding the Strategic Plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred." Existing AMA Policy H-140.837: Policy on Conduct at AMA Meetings and Events is of limited scope and does not fully address the context of these recent events. There is an urgent and pressing need to expand AMA policy protecting free speech and civil discourse in the proceedings of our AMA.

N.B.: Many of the concepts and some of the language in this resolution originate in the Philadelphia Statement (The Philadelphia Statement, August 2020, <https://thephillystatement.org/>)

RELEVANT AMA POLICY**Protection of Physician Freedom of Speech H-435.940**

Our AMA supports a physician's First Amendment right to express opinions relating to medical issues.

Citation: BOT Rep. 14, I-18

Policy on Conduct at AMA Meetings and Events H-140.837

It is the policy of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

Any type of harassment of any attendee of an AMA hosted meeting, event and other activity, including but not limited to dinners, receptions and social gatherings held in conjunction with an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA business is conducted. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)

The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA); provided, however, that such CEJA member on the CCAM shall be recused from discussion and vote concerning referral by the CCAM of a matter to CEJA for further review and action. The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of

conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. Reporting Violations of the Policy

Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

3. Investigations

All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. Disciplinary Action

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;

- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions.

Consequence for policy violations will be commensurate with the nature of the violation(s).

5. Confidentiality

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. Assent to Policy

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

[Editor's note: Violations of this Policy on Conduct at AMA Meetings and Events may be reported at 800.398.1496 or online at <https://www.lighthouse-services.com/ama>. Both are available 24 hours a day, 7 days a week.

Please note that situations unrelated to this Policy on Conduct at AMA Meetings and Events should not be reported here. In particular, patient concerns about a physician should be reported to the state medical board or other appropriate authority.]

Citation: BOT Rep. 23, A-17; Appended: BOT Rep. 20, A-18; Modified: BOT Rep. 10, A-19; Modified: CCB Rep. 2, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1004
(JUN-21)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery, Arizona, Arkansas, California, District of Columbia, Florida, Mississippi, New Jersey, New York, Oklahoma, South Carolina, Texas, American Society of Anesthesiologists, American Academy of Allergy Asthma and Immunology, American Society of Dermatopathology, Mississippi

Subject: Non-Physician Title Misappropriation

Referred to: Reference Committee B

1 Whereas, Physician assistants (PAs) are valuable members of the physician-led health care
2 team; and
3

4 Whereas, PAs complete a 26-month PA program, followed by 2,000 hours of clinical rotations,
5 which emphasize primary care in ambulatory clinics, physician offices and acute or long-term
6 care facilities, or could complete online programs that do not have clinical hands-on training;
7 and
8

9 Whereas, Physicians--comprised of doctors of allopathic medicine (MDs) and doctors of
10 osteopathic medicine (DOs)--complete a rigorous undergraduate academic curriculum, and a
11 four year (48-month) medical school education program, followed by 3–7 years of residency and
12 12,000-16,000 hours of patient care training; and
13

14 Whereas, There are substantial differences in the education and hands-on clinical training of
15 PAs and physicians, both in depth of knowledge and length of training; and
16

17 Whereas, The American Academy of PAs House of Delegates voted on May 24, 2021 to
18 change their title to “physician associate”; and
19

20 Whereas, A change in title from physician assistant to physician associate falsely implies a
21 corresponding elevation of credentials; and
22

23 Whereas, According to nationwide surveys conducted by the American Medical Association’s
24 Scope of Practice Partnership, 88% of patients believe only medical doctors (MDs and DOs)
25 should be permitted to use the title “physician;” and 79% of patients support state legislation to
26 require all health care advertising materials to clearly designate the level of education, skills and
27 training of all health care professionals; and
28

29 Whereas, Changing the title of physician assistant to physician associate will likely further
30 mislead the public into thinking that PAs have a high level of training commensurate with the
31 training of a physician; and
32

33 Whereas, Efforts to disassemble the physician-led team-based model of health care would
34 further compartmentalize the delivery of health care; and

1 Whereas, As physicians, our number one priority is the health and welfare of our patients;
2 therefore be it
3

4 RESOLVED, That our American Medical Association actively oppose the American Academy of
5 Physician Assistants' (AAPA's) recent move to change the official title of the profession from
6 "Physician Assistant" to "Physician Associate" (Directive to Take Action); and be it further
7

8 RESOLVED, That our AMA actively advocate that the stand-alone title "Physician" be used only
9 to refer to doctors of allopathic medicine (MDs) and doctors of osteopathic medicine (DOs), and
10 not be used in ways that have the potential to mislead patients about the level of training and
11 credentials of non-physician health care workers. (Directive to Take Action)

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

Received: 06/06/21

SPONSORS STATEMENT OF PRIORITY

On May 24, the Academy of Physician Assistants (PAs) House of Delegates voted to change their title to "Physician Associate". This is the latest effort by non-physician organizations to mislead the public concerning their education and training in order to expand their scope of practice. Non-physicians have introduced an unprecedented number of scope of practice expansion legislative initiatives nationwide. The House of Medicine has worked tirelessly to oppose these bills. We strongly support the physician-led team-based model of care and recognize the vital role all providers play in the health care delivery system; however, ambiguous provider nomenclature, misleading advertisements, and the myriad of individuals one encounters at each point of service exacerbates patient uncertainty. The resolution demonstrates our joint opposition to the AAPA title change to ensure our patients know who is providing their care.

REFERRAL CHANGES AND OTHER REVISIONS

June 2021 Special Meeting

REFERRAL CHANGE

WAS	IS NOW
Res. 002 – Sharing Covid-19 Resources	Res. 608 (Ref Comm F)

REVISED REPORTS

- CMS Report 5 – Medical Center Patient Transfer Policies
- CSAPH Report 3 - Addressing Increases in Youth Suicide

RESOLUTIONS WITH ADDITIONAL SPONSORS*

- 003 - Healthcare Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions (American Academy of Pediatrics, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)
- 203 - Ban the Gay/Trans (LGBTQ+) Panic Defense (New York, Medical Student Section)
- 403 - Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America (New Jersey, Obesity Medicine Association, Endocrine Society)
- 507 - Evidence-Based Deferral Periods for MSM Donors of Blood, Corneas and Other Tissues (Colorado, American Academy of Ophthalmology, GLMA: Health Professionals Advancing LGBTQ Equality, American Society of Cataract and Refractive Surgery, Society of Critical Care Medicine, American Society of Transplant Surgeons)
- 706 - Prevent Medicare Advantage Plans from Limiting Care (American Academy of Physical Medicine and Rehabilitation, American Association of Neuromuscular & Electrodiagnostic Medicine)
- 707 - Financial Incentives for Patients to Switch Treatments (American College of Rheumatology, American Gastroenterological Association, American Academy of Ophthalmology, American College of Gastroenterology, American Academy of Dermatology, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology, American Society of Dermatopathology, American Academy of Allergy, Asthma and Immunology, Association for Clinical Oncology)

* Additional sponsors underlined.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials

Presented by: Tripti C. Kataria, MD, Chair

June 11, 2021

Mister Speaker, Members of the House of Delegates:

The Committee on Rules and Credentials met Sunday, June 6, to discuss Late Resolutions 1001 - 1004. The sponsors of the late resolution were given the opportunity to present for the committee's consideration the reason the resolutions could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

- Late 1001 - COVID-19 Crisis in India
- Late 1002 - Prohibition of Racist Characterization Based on Personal Attributes
- Late 1003 - Free Speech and Civil Discourse in our American Medical Association
- Late 1004 - Non-Physician Title Misappropriation

Mister Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank committee members Emily Briggs, MD, Elisa Choi, MD, Loralie Ma, MD, Joshua Mammen, MD, Joseph Sanfrancesco, MD, and Kenath Shamir.

Emily Briggs, MD
American Academy of Family Physicians

Joseph Sanfrancesco, MD *
College of American Pathologists

Elisa Choi, MD
American College of Physicians

Kenath Shamir, MD *
Massachusetts

Loralie D. Ma, MD
Maryland

Tripti C. Kataria, MD, Chair
American Society of Anesthesiologists

Joshua Mammen, MD *
International College of Surgeons - US
Section

* Alternate Delegate

REPORT OF THE BOARD OF TRUSTEES

B of T Report JUN-21

Subject: Distinguished Service Award

Presented by: Russ Kridel, MD, Chair

- 1 The Board of Trustees is pleased to nominate Carolyn C. Meltzer, MD, for the 2021 Distinguished
- 2 Service Award.
- 3
- 4 A nationally recognized physician leader, Dr. Meltzer has effectively promoted diversity, equity,
- 5 inclusion, and well-being as vital to sustained excellence in healthcare through workforce
- 6 development. Her expertise in implicit bias and systemic organizational biases that disadvantage
- 7 underrepresented groups in medicine has inspired and benefited many.
- 8
- 9 Dr. Meltzer's research has focused on the use of imaging technology to enable quantitation of
- 10 biomarkers of brain function. Through her cross-disciplinary imaging research and complementary
- 11 work in unconscious bias, bioethics, gender equity and workforce development, as well as
- 12 organizational culture and leadership studies, Dr. Meltzer has been a catalyst for the mentorship,
- 13 career development, and promotion of women and groups that are historically underrepresented in
- 14 medicine.
- 15
- 16 The Distinguished Service Award may be made to a member of the Association for meritorious
- 17 service in the science and art of medicine, and your Board of Trustees believes that
- 18 Carolyn C. Meltzer, MD, is a most deserving nominee for this, our highest award.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

ORDER OF BUSINESS - OPENING SESSION

**Friday, June 11, 2021
7:00 pm**

- 1. Call to Order by the Speaker - Bruce A. Scott, MD**
- 2. Invocation**
- 3. National Anthem**
- 4. Address of the President - Susan R. Bailey**
- 5. Report of the Executive Vice President - James L. Madara, MD**
- 6. AMA Alliance**
- 7. AMPAC**
- 8. AMA Foundation**
- 9. Remarks of the Speaker - Bruce A. Scott**
- 10. Reports of the Committee on Rules and Credentials - Tripti C. Kataria, MD**
- 11. Nominations of Officers**
- 12. Nominations for Councils of the AMA**
- 13. Nominations for the Council on Ethical and Judicial Affairs**
- 14. Distinguished Service Award**
- 15. Presentation, Correction and Adoption of Minutes of the November 2020 Special Meeting**
- 16. Acceptance of Business**
 - Reports of the Board of Trustees - Russ Kridel, MD, Chair**
 - 01 Annual Report (F)
 - 02 2020 Grants and Donations (Info. Report)
 - 03 AMA 2022 Dues (F)
 - 04 Update on Corporate Relationships (Info. Report)
 - 05 AMA Performance, Activities and Status in 2020 (Info. Report)
 - 06 Annual Update on Activities and Progress in Tobacco Control: March 2020 Through February 2021 (Info. Report)
 - 07 Council on Legislation Sunset Review of 2011 House Policies (B)
 - 08 Plan for Continued Progress Toward Health Equity (Center for Health Equity Annual Report) (Info. Report)
 - 09 Preservation of the Patient-Physician Relationship (G)
 - 10 Protestor Protections (D)
 - 11 Redefining the AMA's Position on ACA and Healthcare Reform (Info. Report)
 - 12 Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment (F)

- 13 Amending the AMA's Medical Staff Rights and Responsibilities (G)
- 14 Pharmaceutical Advertising in Electronic Health Record Systems (B)
- 15 Removing Sex Designation from the Public Portion of the Birth Certificate (D)
- 16 Follow-up on Abnormal Medical Test Findings (D)
- 17* Specialty Society Representation in the House of Delegates - Five-Year Review (Amendments to C&B)
- 18* Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19 (B)

Reports of the Council on Constitution and Bylaws - Madelyn E. Butler, MD, Chair

- 01* Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs (Amendments to C&B)
- 02* AMA Women Physicians Section: Clarification of Bylaw Language (Amendments to C&B)
- 03* Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section) (Amendments to C&B)

Reports of the Council on Ethical and Judicial Affairs - Monique A. Spillman, MD, Chair

- 01* CEJA's Sunset Review of 2011 House Policies (Amendments to C&B)
- 02* Short-term Medical Service Trips (Amendments to C&B)
- 03* Amendment to Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues" (Amendments to C&B)
- 04* Augmented Intelligence & the Ethics of Innovation in Medicine (Info. Report)
- 05* Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report (Info. Report)

Opinion(s) of the Council on Ethical and Judicial Affairs - Monique A. Spillman, MD, Chair

- 01* Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients (Info. Report)
- 02* Amendment to Opinion 8.7, "Routing Universal Immunization of Physicians" (Info. Report)

Report of the Council on Long Range Planning and Development - Shannon Pryor, MD, Chair

- 01* Demographic Characteristics of the House of Delegates and AMA Leadership (Info. Report)

Reports of the Council on Medical Education - Liana Puscas, MD, Chair

- 01* Council on Medical Education Sunset Review of 2011 House Policies (C)
- 02* Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses (C)
- 03* Optimizing Match Outcomes (C)
- 04* Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice (C)
- 05* Promising Practices Among Pathway Programs to Increase Diversity in Medicine (C)

Reports of the Council on Medical Service - Lynda M. Young, MD, Chair

- 01* Council on Medical Service's Sunset Review of 2011 House Policies (G)
- 02* Continuity of Care for Patients Discharged from Hospital Settings (A)
- 03* Universal Basic Income Pilot Studies (G)
- 04* Promoting Accountability in Prior Authorization (G)
- 05# Medical Center Patient Transfer Policies (REVISED) (G)
- 06* Urgent Care Centers (G)
- 07* Addressing Equity in Telehealth (A)
- 08* Licensure and Telehealth (A)
- 09* Addressing Payment in Delivery in Rural Hospitals (G)

Reports of the Council on Science and Public Health - Kira A. Geraci-Ciardullo, MD, Chair

- 01* Council on Science and Public Health Sunset Review of 2011 House Policies (D)
- 02* Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings (E)
- 03# Addressing Increases in Youth Suicide (REVISED) (D)

Joint Report(s)

- 01* CCB/CLRPD Joint Council Sunset Review of 2011 House Policies (F)

Report of the Speakers - Bruce A. Scott, MD, Speaker; Lisa Bohman Egbert, MD, Vice Speaker

- 01 Recommendations for Policy Reconciliation (Info. Report)

-- EXTRACTION OF INFORMATIONAL REPORTS --

Memorial Resolutions

Resolutions

- 001 Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD) (Amendments to C&B)
- 002 Sharing Covid-19 Resources - MOVED TO REF COMM F (NOW 608) (Amendments to C&B)
- 003* Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions (Amendments to C&B)
- 004* AMA Resident/Fellow Councilor Term Limits (Amendments to C&B)
- 005* Resident and Fellow Access to Fertility Preservation (Amendments to C&B)
- 006* Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients (Amendments to C&B)
- 007* Nonconsensual Audio/Video Recording at Medical Encounters (Amendments to C&B)
- 008* Organ Transplant Equity for Persons with Disabilities (Amendments to C&B)
- 009* Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties (Amendments to C&B)
- 010* Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses (Amendments to C&B)
- 011* Truth, Reconciliation and Healing in Medicine and Medical Education (Amendments to C&B)
- 012* Increasing Public Umbilical Cord Blood Donations in Transplant Centers (Amendments to C&B)
- 013* Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism (Amendments to C&B)
- 014* Supporting the Study of Reparations as a Means to Reduce Racial Inequalities (Amendments to C&B)
- 015* Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals (Amendments to C&B)
- 016* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers (Amendments to C&B)
- 017* Improving the Health and Safety of Sex Workers (Amendments to C&B)
- 018* LGBTQ+ Representation in Medicine (Amendments to C&B)
- 019* Evaluating Scientific Journal Articles for Racial and Ethnic Bias (Amendments to C&B)
- 020* Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954 (Amendments to C&B)
- 021* Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions (Amendments to C&B)
- 022# Maternal Levels of Care Standards of Practice (Amendments to C&B)
- 023# Pandemic Ethics and the Duty of Care (Amendments to C&B)
- 024# AMA Bylaws Language on AMA Young Physicians Section Governing Council Eligibility (Amendments to C&B)
- 101 Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits (A)
- 102 Bundling Physician Fees with Hospital Fees (A)
- 103 COBRA for College Students (A)
- 104 Medicaid Tax Benefits (A)
- 105 Effects of Telehealth Coverage and Payment Parity on Health Insurance Premiums (A)
- 106 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored? (A)
- 107* Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance (A)
- 108* Implant Associated Anaplastic Large Cell Lymphoma (A)
- 109* Support for Universal Internet Access (A)
- 110* Healthcare Marketplace Plan Selection (A)

111* Towards Prevention of Hearing-Loss Associated Cognitive Impairment (A)
112* Fertility Preservation Benefits for Active-Duty Military Personnel (A)
113* Support for Universal Internet Access (A)
114* Reimbursement of School-Based Health Centers (A)
115* Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration (A)
116* Caps on Insulin Co-Payments for Patients with Insurance (A)
117* Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System (A)
118# Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient (A)
119# Caps on Insulin Copayments with Insurance (A)
120# Postpartum Maternal Healthcare Coverage Under Children's Insurance (A)
121# Medicaid Dialysis Policy for Undocumented Patients (A)
122# Developing Best Practices for Prospective Payment Models (A)
123# Medicare Eligibility at Age 60 (A)
201 Ensuring Continued Enhanced Access to Healthcare via Telemedicine and Telephonic Communication (B)
202 Prohibit Ghost Guns (B)
203 Ban the Gay/Trans (LGBTQ+) Panic Defense (B)
204 Insurers and Vertical Integration (B)
205 Protection of Peer-Review Process (B)
206* Redefining the Definition of Harm (B)
207* Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education (B)
208* Increasing Residency Positions for Primary Care (B)
209* Making State Health Care Cost Containment Council Datasets Free of Cost and Readily Available for Academic Research (B)
210* Ransomware and Electronic Health Records (B)
211* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-Dose Medications for Multiple Patients (B)
212* ONC's Information Blocking Regulations (B)
213* CMMI Payment Reform Models (B)
214* Status of Immigration Laws, Rules, and Legislation During National Crises and Addressing Immigrant Health Disparities (B)
215* Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs (B)
216* Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies (B)
217* Amending H-150.962, Quality of School Lunch Program to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs During COVID-19 (B)
218* Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity (B)
219* Oppose Tracking of People who Purchase Naloxone (B)
220* Equal Access to Adoption for the LGBTQ Community (B)
221* Support for Mental Health Courts (B)
222* Advocating for the Amendment of Chronic Nuisance Ordinances (B)
223* Supporting Collection of Data on Medical Repatriation (B)
224* Using X-Ray and Dental Records for Assessing Immigrant Age (B)
225# Insurance Coverage Transparency (B)
226# Interest-Based Debt Burden on Medical Students and Residents (B)
227# Audio-Only Telehealth for Risk Adjusted Payment Models (B)
228# COVID-19 Vaccination Rollout to Emergency Departments and Urgent Care Facilities (B)
229# Classification and Surveillance of Maternal Mortality (B)
230# Considerations for Immunity Credentials During Pandemics and Epidemics (B)
231# Increasing Access to Menstrual Hygiene Products (B)
232# Preventing Inappropriate Use of Patient Protected Medical Information in the Vaccination Process (B)

301 Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic (C)

302 Non-Physician Post-Graduate Medical Training (C)

303 Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE (C)

304* Decreasing Financial Burdens on Residents and Fellows (C)

305* Non-Physician Post-Graduate Medical Training (C)

306* Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training (C)

307* Updating Current Wellness Policies and Improving Implementation (C)

308* Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination Requirement for Medical Licensure (C)

309* Supporting GME Program Child Care Residency Training (C)

310* Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine (C)

311* Student Loan Forgiveness (C)

312* AMA Support for Increased Funding for the American Board of Preventive Medicine Residency Programs (C)

313* Fatigue Mitigation Respite for Faculty and Residents (C)

314* Standard Procedure for Accommodations in USMLE and NBME Exams (C)

315* Representation of Dermatological Pathologies in Varying Skin Tones (C)

316* Improving Support and Access for Medical Students with Disabilities (C)

317# Medical Honor Society Inequities and Reform (C)

318# The Impact of Private Equity on Medical Training (C)

319# The Effect of the COVID-19 Pandemic on Graduate Medical Education (C)

401 Universal Access for Essential Public Health Services (D)

402 Modernization and Standardization of Public Health Surveillance Systems (D)

403* Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America (D)

404* Support for Safe and Equitable Access to Voting (D)

405* Traumatic Brain Injury and Access to Firearms (D)

406* Attacking Disparities in Covid-19 Underlying Health Conditions (D)

407* Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities (D)

408* Screening for HPV-Related Anal Cancer (D)

409* Weapons in Correctional Healthcare Settings (D)

410* Ensuring Adequate Health Care Resources to Address the Long COVID Crisis (D)

411* Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens (D)

412* Addressing Maternal Discrimination and Support for Flexible Family Leave (D)

413* Call for Increased Funding and Research for Post Viral Syndromes (D)

414* Call for Improved Personal Protective Equipment Design and Fitting (D)

415* Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles (D)

416* Expansion on Comprehensive Sexual Health Education (D)

417* Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925 (D)

418* Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis (PrEP) for HIV (D)

419* Student-Centered Approaches for Reforming School Disciplinary Policies (D)

420# Impact of Social Networking Services on the Health of Adolescents (D)

421# Medical Misinformation in the Age of Social Media (D)

501 Ensuring Correct Drug Dispensing (E)

502 Scientific Studies Which Support Legislative Agendas (E)

503 Access to Evidence-Based Addiction Treatment in Correctional Facilities (E)

504* Healthy Air Quality (E)
505* Personal Care Product Safety (E)
506* Wireless Devices and Cell Tower Health and Safety (E)
507* Evidence-Based Deferral Periods for MSM Donors for Blood, Corneas and Other Tissues (E)
601* \$100 Member Annual Dues Payment Through 2023 (F)
602* Timely Promotion and Assistance in Advance Care Planning and Advance Directives (F)
603* AMA Urges Health and Life Insurers to Divest from Investments in Fossil Fuels (F)
604* Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis (F)
605* Amending G-630.140, Lodging, Meeting Venues and Social Functions (F)
606* AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations (F)
607# Support for Texas-CARES Program (F)
608# Sharing Covid-19 Resources (F)
609# COVID-19 Crisis in Asia (F)
610# Promoting Equity in Global Vaccine Distribution (F)
701 Physician Burnout is an OSHA Issue (G)
702 Addressing Inflammatory and Untruthful Online Ratings (G)
703 Employed Physician Contracts (G)
704 Eliminating Claims Data for Measuring Physician and Hospital Quality (G)
705* Improving the Prior Authorization Process (G)
706* Prevent Medicare Advantage Plans from Limiting Care (G)
707* Financial Incentives for Patients to Switch Treatments (G)
708* Medicare Advantage Record Requests (G)
709# Insurance Promotion of Preventive Care Services via Incentive-Based Programs (G)
710# Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings (G)
711# Opposition to Elimination of "Incident-to" Billing for Non-Physician Practitioners (G)

17. Report of the Resolution Committee

18. Report of the Committee on Rules and Credentials - Tripti C. Kataria, MD, Chair

- Late Resolutions

19. Unfinished Business and Announcements - Bruce A. Scott, MD

* contained in the Handbook Addendum

contained in the Friday Tote

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 17* Specialty Society Representation in the House of Delegates - Five-Year Review

CC&B Report(s)

- 01* Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs
- 02* AMA Women Physicians Section: Clarification of Bylaw Language
- 03* Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section)

CEJA Report(s)

- 01* CEJA's Sunset Review of 2011 House Policies
- 02* Short-term Medical Service Trips
- 03* Amendment to Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues"

Report of the Speakers

- 02 Report of the Election Task Force

Resolution(s)

- 001 Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD)
- 002 Sharing Covid-19 Resources - MOVED TO REF COMM F (NOW 608)
- 003* Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions
- 004* AMA Resident/Fellow Councilor Term Limits
- 005* Resident and Fellow Access to Fertility Preservation
- 006* Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients
- 007* Nonconsensual Audio/Video Recording at Medical Encounters
- 008* Organ Transplant Equity for Persons with Disabilities
- 009* Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties
- 010* Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses
- 011* Truth, Reconciliation and Healing in Medicine and Medical Education
- 012* Increasing Public Umbilical Cord Blood Donations in Transplant Centers
- 013* Combatting Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
- 014* Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
- 015* Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals
- 016* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
- 017* Improving the Health and Safety of Sex Workers
- 018* LGBTQ+ Representation in Medicine
- 019* Evaluating Scientific Journal Articles for Racial and Ethnic Bias
- 020* Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
- 021* Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
- 022# Maternal Levels of Care Standards of Practice
- 023# Pandemic Ethics and the Duty of Care
- 024# AMA Bylaws Language on AMA Young Physicians Section Governing Council Eligibility

Reference Committee A

CMS Report(s)

- 02* Continuity of Care for Patients Discharged from Hospital Settings
- 07* Addressing Equity in Telehealth
- 08* Licensure and Telehealth

Resolution(s)

- 101 Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits
- 102 Bundling Physician Fees with Hospital Fees
- 103 COBRA for College Students
- 104 Medicaid Tax Benefits
- 105 Effects of Telehealth Coverage and Payment Parity on Health Insurance Premiums
- 106 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?
- 107* Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance
- 108* Implant Associated Anaplastic Large Cell Lymphoma
- 109* Support for Universal Internet Access
- 110* Healthcare Marketplace Plan Selection
- 111* Towards Prevention of Hearing-Loss Associated Cognitive Impairment
- 112* Fertility Preservation Benefits for Active-Duty Military Personnel
- 113* Support for Universal Internet Access
- 114* Reimbursement of School-Based Health Centers
- 115* Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration
- 116* Caps on Insulin Co-Payments for Patients with Insurance
- 117* Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System
- 118# Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient
- 119# Caps on Insulin Copayments with Insurance
- 120# Postpartum Maternal Healthcare Coverage Under Children's Insurance
- 121# Medicaid Dialysis Policy for Undocumented Patients
- 122# Developing Best Practices for Prospective Payment Models
- 123# Medicare Eligibility at Age 60

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
- 225# Insurance Coverage Transparency
- 226# Interest-Based Debt Burden on Medical Students and Residents
- 227# Audio-Only Telehealth for Risk Adjusted Payment Models
- 228# COVID-19 Vaccination Rollout to Emergency Departments and Urgent Care Facilities
- 229# Classification and Surveillance of Maternal Mortality
- 230# Considerations for Immunity Credentials During Pandemics and Epidemics
- 231# Increasing Access to Menstrual Hygiene Products
- 232# Preventing Inappropriate Use of Patient Protected Medical Information in the Vaccination Process

Reference Committee C

CME Report(s)

- 01* Council on Medical Education Sunset Review of 2011 House Policies
- 02* Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses
- 03* Optimizing Match Outcomes
- 04* Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice
- 05* Promising Practices Among Pathway Programs to Increase Diversity in Medicine

Resolution(s)

- 301 Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic
- 302 Non-Physician Post-Graduate Medical Training
- 303 Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE
- 304* Decreasing Financial Burdens on Residents and Fellows
- 305* Non-Physician Post-Graduate Medical Training
- 306* Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training
- 307* Updating Current Wellness Policies and Improving Implementation
- 308* Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination Requirement for Medical Licensure
- 309* Supporting GME Program Child Care Residency Training
- 310* Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine
- 311* Student Loan Forgiveness
- 312* AMA Support for Increased Funding for the American Board of Preventive Medicine Residency Programs
- 313* Fatigue Mitigation Respite for Faculty and Residents
- 314* Standard Procedure for Accommodations in USMLE and NBME Exams
- 315* Representation of Dermatological Pathologies in Varying Skin Tones
- 316* Improving Support and Access for Medical Students with Disabilities
- 317# Medical Honor Society Inequities and Reform
- 318# The Impact of Private Equity on Medical Training
- 319# The Effect of the COVID-19 Pandemic on Graduate Medical Education

Reference Committee D

BOT Report(s)

- 10 Protestor Protections
- 15 Removing Sex Designation from the Public Portion of the Birth Certificate
- 16 Follow-up on Abnormal Medical Test Findings

CSAPH Report(s)

- 01* Council on Science and Public Health Sunset Review of 2011 House Policies
- 03# Addressing Increases in Youth Suicide (REVISED)

Resolution(s)

- 401 Universal Access for Essential Public Health Services
- 402 Modernization and Standardization of Public Health Surveillance Systems
- 403* Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America
- 404* Support for Safe and Equitable Access to Voting
- 405* Traumatic Brain Injury and Access to Firearms
- 406* Attacking Disparities in Covid-19 Underlying Health Conditions
- 407* Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities
- 408* Screening for HPV-Related Anal Cancer
- 409* Weapons in Correctional Healthcare Settings
- 410* Ensuring Adequate Health Care Resources to Address the Long COVID Crisis
- 411* Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens
- 412* Addressing Maternal Discrimination and Support for Flexible Family Leave
- 413* Call for Increased Funding and Research for Post Viral Syndromes
- 414* Call for Improved Personal Protective Equipment Design and Fitting
- 415* Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles
- 416* Expansion on Comprehensive Sexual Health Education
- 417* Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925
- 418* Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis (PrEP) for HIV
- 419* Student-Centered Approaches for Reforming School Disciplinary Policies
- 420# Impact of Social Networking Services on the Health of Adolescents
- 421# Medical Misinformation in the Age of Social Media

Reference Committee E

CSAPH Report(s)

02* Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings

Resolution(s)

501 Ensuring Correct Drug Dispensing

502 Scientific Studies Which Support Legislative Agendas

503 Access to Evidence-Based Addiction Treatment in Correctional Facilities

504* Healthy Air Quality

505* Personal Care Product Safety

506* Wireless Devices and Cell Tower Health and Safety

507* Evidence-Based Deferral Periods for MSM Donors for Blood, Corneas and Other Tissues

Reference Committee F

BOT Report(s)

- 01 Annual Report
- 03 AMA 2022 Dues
- 12 Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment

Joint Report(s)

- 01* CCB/CLRPD Joint Council Sunset Review of 2011 House Policies

Resolution(s)

- 601* \$100 Member Annual Dues Payment Through 2023
- 602* Timely Promotion and Assistance in Advance Care Planning and Advance Directives
- 603* AMA Urges Health and Life Insurers to Divest from Investments in Fossil Fuels
- 604* Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis
- 605* Amending G-630.140, Lodging, Meeting Venues and Social Functions
- 606* AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations
- 607# Support for Texas-CARES Program
- 608# Sharing Covid-19 Resources
- 609# COVID-19 Crisis in Asia
- 610# Promoting Equity in Global Vaccine Distribution

Reference Committee G

BOT Report(s)

- 09 Preservation of the Patient-Physician Relationship
- 13 Amending the AMA's Medical Staff Rights and Responsibilities

CMS Report(s)

- 01* Council on Medical Service's Sunset Review of 2011 House Policies
- 03* Universal Basic Income Pilot Studies
- 04* Promoting Accountability in Prior Authorization
- 05# Medical Center Patient Transfer Policies (REVISED)
- 06* Urgent Care Centers
- 09* Addressing Payment in Delivery in Rural Hospitals

Resolution(s)

- 701 Physician Burnout is an OSHA Issue
- 702 Addressing Inflammatory and Untruthful Online Ratings
- 703 Employed Physician Contracts
- 704 Eliminating Claims Data for Measuring Physician and Hospital Quality
- 705* Improving the Prior Authorization Process
- 706* Prevent Medicare Advantage Plans from Limiting Care
- 707* Financial Incentives for Patients to Switch Treatments
- 708* Medicare Advantage Record Requests
- 709# Insurance Promotion of Preventive Care Services via Incentive-Based Programs
- 710# Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings
- 711# Opposition to Elimination of "Incident-to" Billing for Non-Physician Practitioners

Informational Reports

BOT Report(s)

- 02 2020 Grants and Donations
- 04 Update on Corporate Relationships
- 05 AMA Performance, Activities and Status in 2020
- 06 Annual Update on Activities and Progress in Tobacco Control: March 2020 Through February 2021
- 08 Plan for Continued Progress Toward Health Equity (Center for Health Equity Annual Report)
- 11 Redefining the AMA's Position on ACA and Healthcare Reform

CEJA Opinion(s)

- 01* Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients"
- 02* Amendment to Opinion 8.7, "Routing Universal Immunization of Physicians"

CEJA Report(s)

- 04* Augmented Intelligence & the Ethics of Innovation in Medicine
- 05* Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report

CLRPD Report(s)

- 01* Demographic Characteristics of the House of Delegates and AMA Leadership

Report of the Speakers

- 01 Recommendations for Policy Reconciliation

* contained in the Handbook Addendum

contained in the Friday Tote

Report of the AMPAC Board of Directors

Presented by: Stephen A. Imbeau, MD
Chair, AMPAC

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities this election cycle. As the nation slowly returns to normal, the COVID-19 pandemic will continue to have long-term effects on health care delivery in this country. The hardships faced by the medical community these past eighteen months have only strengthened our commitment to our mission - to provide physicians with opportunities to support candidates for federal office who have demonstrated their support for organized medicine through a willingness to work with physicians to strengthen our ability to care for America's patients. In addition, we continue to help physician advocates grow their abilities through our political education programs, which include intensive training sessions that provide them with all the tools necessary to successfully take the next step and work on campaigns or run for office themselves.

AMPAC Membership Fundraising

AMPAC is celebrating 60 Years of Political Action! In 1961 the members at the AMA realized the need for an advocacy arm to enhance the mission of the AMA and that year AMPAC was created as the first non-union Political Action Committee (PAC) in the country and has been advancing the mission of the AMA ever since.

We have had many achievements over the past sixty years that have had a lasting impact for physicians and medicine. AMPAC was the first professional member association PAC to use Independent Expenditures (IEs), which paved the way for the advocacy profession to significantly impact elections through paid advertising independently of a candidate or party in the political arena. AMPAC's campaign schools, established in 1985 has trained over 1,900 AMA members and spouses to be advocates and candidates and includes three physician graduate members that sit in Congress today. These are just a few of the advances AMPAC has made for the medical community over the last sixty years. We look forward to achieving many more, however the future of AMPAC's success relies on the ability to maximize funding from within our HOD.

Thank you to the House of Delegate members who have already contributed to AMPAC this year and especially those at the Capitol Club level. For those who have not had a chance to do so yet, we encourage you to make an investment today. Each year AMPAC's goal is to have 100% HOD AMPAC participation and so far, this year, we have only 30% HOD AMPAC participation. As a leader, we ask for your support during this special anniversary year, so help increase AMPAC participation in the HOD by visiting AMPACOnline.org to contribute. AMPAC is also hosting a virtual booth during this meeting, so visit AMPAC's website for more details and to view the schedule.

Finally, AMPAC is hosting a virtual event with Jonathan Swan, National Political Reporter for *Axios*. The virtual event is an invitation only event for all 2021 Capitol Club members and will take place on Tuesday, June 15 at 12:00 p.m. Central time. This will be an event you will not want to miss, and we hope that many of you will be able to attend. AMPAC's sixtieth anniversary is something everyone can be proud of, so we hope to count on the support of our House of Delegate members to make AMPAC's 60th year the best one yet.

Political Action

AMPAC has begun its normal process of considering contributions to candidates for the U.S. House of Representatives and the Senate for the 2022 elections. Because it is so early in the cycle, expect a slow pace of contributions limited only to those incumbents who are members of their parties' leadership, on key committees or otherwise in an important position to advance AMA priorities currently moving in Congress. The impact of

Congressional redistricting is another important factor that will drive AMPAC towards a very cautious and deliberative approach to getting involved in races at this early date. Seven states—California, Illinois, Michigan, New York, Ohio, Pennsylvania, and West Virginia— will lose a seat. Five states—Colorado, Florida, Montana, North Carolina, and Oregon—are gaining one seat, and Texas will gain two. The highly contentious political process that will unfold in these and other states around the country could dramatically change race dynamics in a number of contests. Incumbents could be drawn together into one district forcing a member vs. member race. In other instances, the makeup of a congressional district may change so much that the incumbent decides to retire or jump to run in a neighboring district instead. In short, the 2022 political landscape remains murky to say the least and AMPAC will act accordingly and not rush to get involved in races that may look very different in a mere matter of months.

Political Education Programs

Over the course of two weekends in January, physicians, medical students, physician spouses and state medical society staff from across the country took part in the 2020 Campaign School held virtually due to the ongoing COVID-19 pandemic. During the program, twenty-four participants were placed into virtual campaign teams and with a hands-on approach our team of political experts walked them through a simulated campaign, teaching each of them everything they need to know to run a successful race as either a candidate or campaign staff. Senator John Barrasso, MD (WY), a former program graduate, was the keynote speaker and AMPAC is happy to report that the virtual program received high marks from participants, many of whom are seriously considering a run for public office this cycle. Dates and format have not been announced for the 2021 Campaign School this fall.

Due to the COVID-19 pandemic, AMPAC announced that the 2021 Candidate Workshop would also be held virtually this year. Building off the success of the virtual Campaign School, AMPAC staff worked with program trainers to convert the one-and-a-half-day in-person programming into a virtual format. Held over the course of two weekends in May, twenty-six physicians, medical students and state society staff participants learned the skills and strategic approach they will need as a candidate out on campaign trail. During the one-and-a-half-day program, participants learned how and when to make the decision to run, the importance of a disciplined campaign plan and message, the secrets of effective fundraising, the role of spouse and family and much more. Senator Bill Cassidy, MD (LA) and Representative Ami Bera, MD (CA), both former program graduates, provided taped remarks and the keynote session, respectively. AMPAC is proud to report that the virtual program also receives high marks from participants.

AMPAC is also proud to announce that Dr. Theresa Rohr-Kirchgraber was selected the winner of the 2021 AMPAC Award for Political Participation. This award recognizes an AMA or AMA Alliance member for their outstanding work through volunteer activities in a political campaign or a significant health care related election issue such as a ballot initiative or referendum. Dr. Rohr-Kirchgraber is from Indiana and was nominated by her peers on IMPAC and ISMA, as having demonstrated standout contributions through her efforts in political campaigns, fundraising, state and federal PAC education, and garnering support for healthcare related issues last election cycle. She spent a significant amount of time and played a vital role in campaign and fundraising for various initiatives that impacted her community. Dr. Rohr-Kirchgraber will be honored at the AMPAC Capitol Club event to be held virtually during the Annual Meeting.

Conclusion

On behalf of the AMPAC Board of Directors, I would like to thank all members of the House of Delegates who support AMPAC and the work we do. Your continued involvement in political and grassroots activities ensures organized medicine a powerful voice in Washington, DC.

REPORT 03 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (June, 2021)
Addressing Increases in Youth Suicide
(Reference Committee D)

EXECUTIVE SUMMARY

Objective. In the United States, suicide is the 10th overall leading cause of death. Suicides are a preventable cause of death and have devastating effects on families, peers, and communities. Youth and young adult suicide rates rose 54.7 percent from 2007 to 2018 even before the major behavioral and psychological disruptions caused by the COVID-19 pandemic.¹ Despite a small decrease in suicide mortality in 2018 and 2019 data, suicide deaths in youth and young adults overall have been steadily increasing since 2007 and in 2019 suicide was the second leading cause of deaths among those 10-24 years of age.² Due to the alarming increase in suicide and suicide risk in youth and young adults, the Council on Science and Public Health initiated this report to further examine this issue and to provide relevant updates to American Medical Association (AMA) policy.

Methods. English-language articles were selected from a search of the PubMed database through January of 2021 using the search terms “teen,” “youth,” and “adolescent,” coupled with “suicide,” “suicide contagion,” “suicidal ideation,” and “suicidal thoughts and behavior.” Related search terms linked with the above were “mental health,” “substance use,” “trauma,” “ACEs,” “LGBTQ,” and “bullying.” Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

Results. Increases in suicides and suicide attempts have occurred among both male and female youth, with males using more lethal means such as firearms in completed suicides. Youth and young adults in the Native American/Alaska Native demographic groups show the highest number of completed suicides and attempts. Increases in instances of cyberbullying are an important factor associated with youth suicide and requires additional attention. Increases in screen time and in the use of digital devices, the internet, and social networking sites are associated with decreases in time sleeping and increases in depression. Additionally, stresses and disruption associated with the COVID-19 pandemic, such as physical distancing and isolation, have worsened mental health for some youth and possibly increased suicidal ideation. Importantly, evidence clearly notes that when co-occurring mental illness (depression, anxiety), substance use disorder, adverse childhood experiences, or other stressors are present, the risk for suicidal thoughts or behavior increases.

Conclusions. Enhancing physician capability and capacity to screen for, identify, and respond to risk factors for youth suicide are essential to effective suicide prevention efforts. Physicians who see patients in these age groups, and not solely pediatric psychiatrists and addiction medicine physicians, should have access to the tools to identify acute risk and respond with appropriate clinical interventions, linkages to appropriate counseling services, and safety planning. They should also be able to identify and promote relevant protective factors to mitigate the impact of underlying risk factors. Collectively, physicians, parents, teachers, peers, clergy, youth ministers, social workers, counselors, and others, are critical in identifying when a young person is experiencing a period of imminent risk and assisting in preventing suicide attempts.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 03-JUN-21

Subject: Addressing Increases in Youth Suicide

Presented by: Kira A. Geraci-Ciardullo, MD, MPH, Chair

Referred to: Reference Committee D

1 INTRODUCTION

2
3 In the United States, suicide is the 10th overall leading cause of death. Suicides are a preventable
4 cause of death and have devastating effects on families and communities. Suicides and suicide
5 attempts among youth, ages 10-24 have increased steadily since 2007. Data shows that although
6 suicides remained relatively stable in this age group from 2000 to 2007, rates started to rise in 2007
7 and increased 54.7 percent through 2018.¹ While we do not yet know the full impact of the
8 COVID-19 pandemic on youth suicide, the potential mental health consequences of COVID-
9 related stressors are of concern. As a result of the steady increase in youth suicides, the Council on
10 Science and Public Health initiated this report to understand current risk and protective factors,
11 examine evidence-based interventions for youth and young adult suicide, and to update American
12 Medical Association (AMA) policy accordingly.

13
14 The focus of this report will be on children, adolescents, and young adults age 10-24, hereinafter
15 referred to in this report as youth. Data and trends in suicide in populations beyond this age group,
16 while important, are outside the scope of this report.

18 METHODS

19
20 English-language articles were selected from a search of the PubMed database through January of
21 2021 using the search terms “teen,” “youth,” and “adolescent,” coupled with “suicide,” “suicide
22 contagion,” “suicidal ideation,” “and “suicidal thoughts and behavior.” Related search terms linked
23 with the above were “mental health,” “substance use,” “trauma,” “ACEs,” “LGBTQ,” and
24 “bullying.” Additional articles were identified from a review of the references cited in retrieved
25 publications. Searches of selected medical specialty society and international, national, and local
26 government agency websites were conducted to identify clinical guidelines, position statements,
27 and reports.

28
29 Much of the literature reviewed for this report uses the term “suicidal thoughts and behavior” or
30 “STB” as shorthand to describe suicidal thoughts, ideation, planning, and suicide attempts. Non-
31 suicidal self-injury (NSSI) is differentiated in the literature in the United States whereas in Europe
32 it might be included as an STB. For the purposes of this report, the abbreviation STB will be used
33 to mean suicidal thoughts, suicidal ideation and planning, and suicide attempts.

BACKGROUND

Addressing youth suicide is a critical and growing public health issue. Suicides in the United States rose since 2000, increasing 30 percent from 2000 to 2016, with rates increasing among all age groups in the 10-24 range and across 42 states. Rates of suicide in the 10-24 age group have risen 57.4 percent from 6.8 per 100,000 in 2007 to 10.7 per 100,000 in 2018. In 2017 approximately 2.4 percent of all students in grades 9-12 reported making a suicide attempt that required treatment by a physician or nurse.³ Suicide was the second-leading cause of death for young people ages 15 to 24, second only to accidents in 2019.² While more recent data suggest there was a modest decrease in youth suicide in 2018 and 2019, overall levels of suicide among youth are still significantly higher than they were ten years before. And since 2019 stress on youth as well as adults has increased in the wake of the disruption associated with the COVID-19 pandemic, such as physical distancing and social isolation^{1,2,4,5}

Total mortality of youth from suicide in 2017 was 6,200 deaths in those age 10-24, with that number rising to 6,807 in 2018.⁶ Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Surveillance Survey (YRBSS) data from 2019 show that more high school students were contemplating suicide, rising from 13.8 percent in 2009 to 18.8 percent in 2019.⁷ Of all high school students in 2019, 8.9 percent reported having attempted suicide, with prevalence estimates highest among females (11.0 percent) and black non-Hispanic students (11.8 percent).³ Completed suicides are more common in males at rates two to four times higher than females, but suicide attempts are 3-9 times more common in females overall.^{8,9} From 2009 through 2019, prevalence of suicide attempts increased overall and particularly increased among female, non-Hispanic white, non-Hispanic black, and 12th-grade students.^{7,10}

STB varies by race and ethnicity among youth. Native American Indian/Alaska Natives have had the highest suicide rate over the last 20 years. While suicide rates have historically been higher among White individuals than Black individuals, data suggests that suicide risk is increasing among Black youth. One study showed higher incidence of STB for Black youth in the 5-12 age group than White counterparts.¹¹ There is data showing overall increase in the rate of STB among Black youth age 12-17 through the period of 1991-2017, while rates for STB among White youth in that age group have decreased.¹⁰ Rates of STB in Hispanic/Latinx female young adults also increased between 2000 and 2015.^{12,13} In addition, sexual and gender minority youth are more likely to engage in suicidal behavior than their non-LGBTQ peers. It is important to understand the impact of structural racism, historical trauma, and accumulative stress on mental health in minority and historically marginalized communities, may contribute to depression and other risk factors for STB.¹⁴⁻¹⁶

In 2019 firearms were the leading cause of suicide death in those age 15-24 and the second leading cause of suicide death for those in the 10-14 age group. Suffocation is the other leading cause of suicide death among those 10-24. Firearms as a means of suicide have trended upward for young females and deaths from poisonings have decreased.^{2,5} In 2018, the Council on Science and Public Health released a report adopted by the House of Delegates on "The Physician's Role in Firearm Safety and recognized the role of firearms in suicides and encouraged physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.¹⁷

CURRENT AMA POLICY

Highlights of AMA policy related to youth suicide include recognizing teen and young adult suicide as a serious health concern Policy H-60.937, "Teen and Young Adult Suicide in the United

States.” Policy D-350.988, “American Indian / Alaska Native Teen Suicide” encourages significant funding for suicide prevention and intervention directed toward American Indian/Alaska Native communities. Policy H-60.927, “Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations,” also recognizes the special risk for LGBTQ+ teens and calls for partnering with public and private organizations to help reduce suicide among these teens. Policy H-515.952, “Adverse Childhood Experiences and Trauma-Informed Care,” recognizes the importance of trauma-informed care and the impact of adverse childhood experiences (ACEs) and trauma on patient health.

Policy H-60.911 “Harmful Effects of Screen Time in Children” encourages physicians to “assess pediatric patients and educate parents about amount of screen time, physical activity and sleep habits” and to advocate for education in schools about balancing screen time, physical activity, and sleep. Policy H-515.959 “Reduction of Online Bullying” addresses this urging social networking platforms to “define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging” as part of their Terms of Service agreements. In addition, Policy H-60.943 “Bullying Behaviors Among Children and Adolescents” addresses bullying in several ways, including urging physicians to be aware of the signs and symptoms of bullying in children and teens, to recognize the mental, emotional and physician effects of bullying and to counsel patients and parents on effective interventions and coping strategies.

RISK FACTORS FOR YOUTH SUICIDE

Various behavioral, emotional, psychological, and social risk factors for youth suicide have been well established, and include depression, anxiety, bullying, substance use disorder (SUD), trauma, family history of suicide, sexual orientation or sexual and gender minority status and other stressors.^{18,19} Prior suicide attempts are one of the most serious indicators of risk for subsequent self-harm and suicidal behavior.²⁰ Over 30 percent of youth suicides are preceded by a prior attempt, with boys with previous suicide attempts having a 30-fold increase for risk of a subsequent attempt in comparison with boys with no prior attempts. Girls with previous suicide attempts show a 3-fold increase in risk for subsequent attempts in comparison to girls with no prior attempts.⁸ The presence of multiple factors increases underlying risk. Prevention starts with a thorough understanding of risk factors. Identifying risk factors is essential but does not provide the ability to predict acute suicidality effectively and accurately. Underlying risk factors can exist for years without producing active suicidality and imminent risk of suicide, and no one risk factor alone can be an absolute predictor.^{18,19,21}

Role of Mental Health Disorders

Suicide is closely linked to mental health disorders, mainly depression and other mood disorders.^{22,23} Among all age groups, approximately 90 percent of people who complete a suicide have had at least one mental health disorder.²⁴ Risk is significantly increased for acute suicidality when there are psychotic symptoms and when there are family members who have mental health or SUD issues.^{25,26}

Data shows that depression in youth has been on the rise from 2005 to 2019. The 2019 National Survey on Drug Use and Health (NSDUH) indicates that among teens aged 12-17, rates of major depressive disorder increased 52 percent during the period between 2005 and 2017, and an increase of 63 percent was seen in young adults aged 18-25. Those trends were also accompanied by increases in reports of serious psychological distress and suicide related outcomes (STB and

1 suicide mortality) with a dramatic increase of 71 percent for those aged 18-25.²⁷ More recent
2 statistics show that reports of suicidal ideation, planning, persistent feelings of hopelessness and
3 sadness in high school students rose consistently from 2009 to 2019. More high school aged teens
4 were injured in a suicide attempt during that period as well.⁷ Other trends from 2009 to 2019
5 include the rise of electronic devices and digital media as well as declines in sleep which may be
6 contributors to depression and other mood disorders.²⁷ Lack of availability of mental health
7 services is also a concern. Youth who live in urban and suburban areas have been shown to have
8 greater access to mental health resources than teens who live in rural areas.²⁸ When mental health
9 disorders are not properly addressed, the risk for suicide can increase dramatically.^{19,29}

10 11 *Substance Use Disorder*

12
13 Substance use is a major predictor of STB in youth.^{30,31} Studies have shown that youth who used
14 substances (tobacco, alcohol, cannabis, MDMA, ketamine) exhibit more suicidal behavior. In
15 general, historically, boys exhibit more serious substance use, for example, using alcohol and drugs
16 in larger quantities, with more frequency, and starting at an earlier age than girls. The association
17 between substance use and suicidal behavior, however, is consistent between males and females.³⁰

18 19 *Adverse Childhood Experiences (ACEs)*

20
21 ACEs, including physical, mental, and sexual abuse, physical and emotional neglect, and
22 household dysfunctions such as family mental illness, violence, incarceration, substance use, and
23 divorce, are well documented risk factors for suicide and according to the CDC, are associated with
24 at least five of the ten leading causes of death overall. The higher the number of ACEs experienced,
25 the greater the risk for suicide, and for youth, the risk is greater than in adults. A 2001 study found
26 that an ACE score of 7 or more increased the risk of suicide attempts 51-fold among youth and 30-
27 fold among adults. The study also found that between various forms of abuse, emotional abuse in
28 childhood was the greatest predictor of future suicide attempts and the least addressed by
29 traditional child welfare systems. ACEs increase risk for suicide as well as negative opioid-related
30 outcomes, including overdose. These risk factors due to ACEs are preventable and require urgent
31 attention.³²⁻³⁴

32 33 *COVID-19 Pandemic*

34
35 The COVID-19 pandemic has impacted youth STB and mental health. According to CDC data,
36 from April 2020, the proportion of youth mental health-related emergency department (ED) visits
37 increased and remained elevated through October of 2020. Compared with 2019, the proportion of
38 mental health-related visits for youth aged 12-17 years increased approximately 31 percent. Studies
39 have also identified increased rates of suicide ideation and suicide attempts in 2020 during the
40 COVID-19 pandemic as compared with 2019 rates. The increases correspond to times when
41 COVID-related stressors and community responses were heightened. This increase was seen across
42 demographics in the 11-21 age group and based on routine suicide risk screens in a pediatric ED
43 setting.^{35,36}

44 45 *Stigma*

46
47 Ample evidence exists related to the negative impact of stigma on mental health. Youth learn
48 stigmatizing attitudes from many sources including parents, peers, and media and start to
49 concretize their attitudes in adolescence. Recognition of mental health stigma as a barrier to care
50 for youth is essential for targeted suicide prevention efforts. In addition, myths around suicide

contribute to stigma. Characterization of people who experience STB as “weak” or “cowardly” perpetuate stigma and can inhibit youth from asking for help.³⁷⁻³⁹

Increased Screen Time and Use of Digital Devices Linked to Depression

The increased use of digital devices and social media can be linked to increases in mental health symptoms, including depression, among youth grades 8-12. Use of social media and digital devices also have an association with increases in youth suicides from 2010 to 2015. A review of several studies on social media/internet use and suicide attempts found consistent associations between heavy internet/social media use and suicide attempts of those under the age of 19.⁴⁰ Depressive symptoms, which have a strong correlation with STB, increased together with screen time and social media use. Moreover, youth who spent less time onscreen and on smartphones and more time on non-screen activities (in person visiting, sports, religious activities, reading) reported fewer depression symptoms and suicidal thoughts.^{40,41}

Bullying and Cyberbullying

Although cyberbullying is a new area of research, several investigators report associations with both emotional and physical variables, including loneliness, anxiety, depression, suicidal ideation, and somatic symptoms. Also linked to cyberbullying is an increased risk of STB and self-harm for victims, and an increased risk of STB for perpetrators.⁴²⁻⁴⁵

The effects of bullying can be magnified and intensified by youths’ access to social media, where the typical number of peers in a school and community circle is now expanded to any youth who has access to the internet and social networking sites. Several examples of tragic stories exist in the media of cases where victims experienced repeated instances of bullying that were widely spread over the internet and social media. Teens left behind messages indicating they felt hopeless that the bullying would stop.⁴⁶

A 2013 review of resources for cyberbullying examined interventions and prevention strategies acknowledge that many resources have been developed, but that there must be more research to determine effectiveness and how best to tailor programs to various school settings.⁴⁷ An online cyberbullying information clearinghouse, The Cyberbullying Research Center, provides guides to state laws on cyberbullying, research, and resources for parents, educators, youth and health care providers on addressing cyberbullying.⁴⁸

Suicide Contagion/Clusters

Suicide clusters consist of episodes of multiple suicides that are greater than what would be typical in a specific location, many times in quick succession, and are more common in young people (<25 years) than adults. Approximately 1-5 percent of youth suicides occur in a cluster after a youth dies by suicide. Suicide contagion, which is triggered by exposure to a death by suicide, can increase the risk of suicide in another and has been shown to be a significant factor in youth STB.⁴⁹ The colloquial term often used for this phenomenon is “copy-cat suicide.” Suicide contagion can result from direct exposure such as a suicide of a family member, friend, or classmate or indirect exposure through media or online reports. Youth are especially sensitive to peers’ thoughts and expressions and may be more impacted by media reporting on suicide, suicide clusters, and exposure to a suicidal peer. A study showing a 28.9 percent spike in youth (ages 10-17) suicide across the United States in the months following the release of the fictional Netflix series “13 Reasons Why,” is an example of the influence of media; the show follows a fictional character who ultimately dies by suicide.⁵⁰

Media depictions or social networking posts that romanticize youth suicide may result in suicide contagion and clusters.⁵¹⁻⁵⁶ Guidelines for the media on responsible reporting on suicides for media are available including a collaboratively produced guide called “Recommendations for Suicide Reporting” and the International Association for Suicide Prevention’s (IASP) guide “Preventing Suicide: A Resource for Media Professionals” outlining numerous “dos and don’ts” for media in reporting on suicide. Among the points of guidance are not using language which sensationalizes or normalizes suicide; not presenting suicide as a constructive solution to problems; avoiding explicit descriptions of the method(s) used in a completed suicide; and using sensitivity when interviewing family and friends of suicide victims.^{57,58}

Developmental Characteristics of Adolescence That Increase Vulnerability

Impulsivity in young people is typical and has been shown to be a factor in their vulnerability to suicidal impulses. Research has found that emotion-relevant impulsivity as well as poor control over emotional reactions are more prevalent in adolescence. A type of emotion-relevant impulsivity, negative urgency, which is a strong and immediate need to avoid unpleasant emotions or physical sensations, is a distinct form of impulsivity and is a strong predictor of problem behaviors and STB.⁵⁹ Underdevelopment of the prefrontal areas of the brain and discordant development in the prefrontal and limbic systems are thought to be linked to teen risk taking and impulsivity. The drive to reward seeking without effective inhibitory controls results in a variety of negative outcomes driven by impulsive behaviors, including STB.^{60,61}

PROTECTIVE FACTORS

Enhancing resiliency and identifying protective factors are important ways to mitigate risks for youth suicide. Protective factors include connectedness to supports such as peers, family, community and social institutions, life skills, coping skills access to behavioral and mental health care, and cultural, religious, or personal beliefs that discourage suicide. There are many resources on ways to enhance resiliency in youth that help mitigate suicide risk including developing a positive identity, and age-appropriate empowerment. The Interagency Working Group on Youth Programs composed of representatives from 21 Federal agencies, has a multitude of web-based resources designed to support positive youth development.⁶²⁻⁶⁴

PREVENTION

School Based Suicide Prevention Programs

School based suicide prevention programs fall generally into several categories; suicide awareness and prevention trainings for school personnel, universal suicide prevention curriculum for all students, and targeted or selected interventions for students who are identified as at risk.

Reviews of research in these areas show that there are some benefits in all these approaches, but there is wide variability in methodology and outcome measurements. Research shows that effectiveness of school-based programs has not been well established yet in terms of impact on primary outcomes (numbers of suicides). More recent reviews of studies on school-based programs literature calls for continued and better research to determine which interventions or which combination of interventions are most effective in preventing suicides.^{65,66}

1 *Screening*

2
3 The U.S. Preventive Services Task Force (USPSTF) examined the evidence to determine whether
4 asymptomatic youth should be screened for suicide risk in their 2013 report and found the evidence
5 to clearly establish risks and benefits to be insufficient.⁶⁷ However, the USPSTF does recommend
6 that primary care clinicians screen youth for depression when appropriate systems are in place to
7 ensure adequate diagnosis, treatment, and follow-up. USPSTF also recommends primary care
8 clinicians provide increased focus for their patients during periods of high suicide risk, such as
9 immediately after discharge from a psychiatric hospital or after an emergency department visit for
10 deliberate self-harm. Recent evidence suggests that interventions during these high-risk periods are
11 effective in reducing suicide deaths.⁶⁸⁻⁷⁰ Experts in youth suicide prevention note that effective
12 screening can be a simple conversation beginning with the question: “Are you OK?”⁶⁹

13
14 Currently, there is no recommendation from the American College of Emergency Physicians to
15 institute widespread screening for suicide in Emergency Departments (ED). Some evidence notes
16 that EDs are an ideal place for expanding screening since many youths visit an ED at some point
17 during adolescence. A study using a computerized screening tool, the Computerized Adaptive
18 Screen for Suicidal Youth (CASSY), designed for teens aged 12-17 having an ED visit, accurately
19 predicted a suicide attempt within a three-month period following the ED visit.⁷¹

20 21 *The Joint Commission*

22
23 The Joint Commission has developed seven new and revised elements of performance in
24 accreditation surveys applicable to hospitals, behavioral health care organizations, and accredited
25 critical access hospitals. These new elements are designed to “improve the quality and safety of
26 care for those who are being treated for behavioral health conditions and those who are identified
27 as high risk for suicide.” The revised elements involve environmental risk assessment, use of
28 validated screening tools, evidence-based screening for suicide risk, documentation of overall risk
29 for suicide and mitigation plans, written policies (staff training, reassessment, monitoring high-risk
30 individuals), follow up care, and monitoring whether procedures are effective. It is important to
31 note however, that the new elements of performance for accreditation surveys do not explicitly
32 require that all patients in hospital settings be screened. Despite the allowance for selective
33 screening, some hospital care settings have instituted universal screening of patients and the
34 feasibility of this is an ongoing debate. Other accrediting bodies, specifically the Council on
35 Accreditation (COA) and Commission on Accreditation of Rehabilitation Facilities (CARF), have
36 also made changes to their standards for facilities related to suicide prevention. The movement in
37 this direction will eventually require some adaptation in health care facilities to these new
38 elements.⁷²

39
40 The Joint Commission recommends several evidence-based screening tools for assessing suicide
41 risk in accredited organizations. They include the Columbia Suicide Severity Rating (C-SSR), the
42 Ask Suicide-Screening Questions (ASQ), and the Suicide Behaviors Questionnaire-Revised (SBQ-
43 R). The Patient Health Questionnaire (PHQ-9) is also recommended as a depression screening tool
44 and scale to determine severity.^{73,74}

45 46 *Targeted Prevention Efforts*

47
48 Statistics note that special attention to targeted prevention efforts could be important for sub-
49 populations of youth that are showing higher risk than others for STB. This includes Native
50 American and Native Alaskan males, Black youth, LGBTQ+ teens, and Latina youth. The National
51 Suicide Prevention Lifeline website devotes a page to resources for Native American and Alaskan

populations. All these youth sub-populations could benefit from targeted prevention efforts that are culturally sensitive and community based.⁷⁵⁻⁷⁷

INTERVENTIONS

Access to Mental Health Care

Reportedly, less than half of young people who have died by suicide had received psychiatric care. Increased access to mental health services is needed in addition to community supports, peer supports, school-based programs, college counseling services and social services designed to prevent youth and young adult suicide.²³ Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a suicide prevention resource list of guides, crisis lines, and prevention programs for children and youth.⁷⁸

Medications

Medications used to treat mental health conditions can alleviate symptoms and hopefully mitigate risk of STB. Evidence exists that treatment with antidepressants can result in lower suicide rates overall.^{79,80} Evidence is also available that indicates lithium and clozapine can directly lower suicidal behavior, however the use of these medications is limited because of the time needed to reach therapeutic levels and the narrow therapeutic index of each of these agents. Anxiolytics, sedative-hypnotics, and some antipsychotic medications can be utilized to decrease agitation, anxiety, distress, insomnia, and other symptoms of psychological distress in an acute situation.^{79,81}

An esketamine nasal spray for depression was recently approved by the US Food and Drug Administration (FDA) for use in adult patients who are contemplating suicide and shows promise for relieving acute suicidality and rapidly improving depressive symptoms. Esketamine can relieve symptoms within 24 hours, as opposed to typical antidepressants which can take up to 3-4 weeks to relieve symptoms. This medication is approved for use in adults only. The American Academy of Child and Adolescent Psychiatry (AACAP) has made a statement reiterating that it is not approved by the FDA for use in pediatric patients and cautioning physicians about off-label use.⁸²⁻⁸⁴ Recently, the National Institute of Mental Health (NIMH), released a research update stating that they are supporting multiple new research projects on ketamine and esketamine as well as transcranial magnetic stimulation (TMS) for safety, efficacy and feasibility in youth and young adults who are acutely suicidal. TMS uses magnets to stimulate specific parts of the brain. Both these interventions could produce rapid decrease in severe suicidal thoughts and feelings.⁸⁵

Specific Psychotherapies

Among psychotherapeutic models, cognitive behavioral therapy (CBT) has the most evidence of effectiveness in youth and adults for a variety of disorders, particularly anxiety and depression.⁸⁶ Internet based CBT (iCBT) has also been studied and consistently shows some efficacy in reducing suicide attempts. iCBT has also shown some efficacy in reducing both SUD and STB in youth and is potentially a highly scalable intervention.^{87,88} Additionally, YST-II, a social support program, shows promise in reducing suicidal ideation in youth following a suicide attempt.⁸⁹ A 2018 report of two independent trials on Dialectical Behavioral Therapy (DBT), showed promise for effectiveness with youth experiencing STB.⁹⁰ More research is needed to fully understand the utility of psychotherapies.

FEDERAL EFFORTS TO REDUCE YOUTH SUICIDE

US Department of Health and Human Services

Office of the Surgeon General. Efforts to prevent adult and youth suicide at the federal level in the United States have been led by the U.S. Surgeon General going back to 2001. The National Strategy for Suicide Prevention (NSSP) was the first organized and comprehensive effort on suicide prevention, with the latest revision done in 2012. The NSSP contains four strategic directions that each include a set of goals and objectives: (1) Create supportive environments that promote healthy and empowered individuals, families, and communities (4 goals, 16 objectives); (2) Enhance clinical and community preventive services (3 goals, 12 objectives); (3) Promote the availability of timely treatment and support services (3 goals, 20 objectives); and (4) Improve suicide prevention surveillance collection, research, and evaluation (3 goals, 12 objectives). The NSSP's four strategic directions are meant to work together in a synergistic way to prevent suicide in the nation.

In January of 2021, the Surgeon General released a "Call to Action to Implement the National Strategy for Suicide Prevention," an effort to broaden perceptions of suicide, who is affected, and recognition of the environmental factors as well as individual factors related to suicide risk.^{91,92}

SAMHSA. The National Suicide Prevention Lifeline has been in operation since 2005 and is funded by SAMHSA in partnership with the National Action Alliance for Suicide Prevention (Action Alliance⁹³). The National Suicide Prevention Lifeline is a network of over 160 independently operated crisis call centers nationwide that are linked to a series of toll-free numbers, the most prominent of which is 800-273-TALK. In July 2020, the Federal Communications Commission (FCC) designated the three-digit number 988 for the National Suicide Prevention Lifeline to aid rapid access to suicide prevention and mental health services.^{75,93}

Additionally, SAMHSA recently released an evidence-based guide, "Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth." This guide is targeted to healthcare professionals and a broad range of stakeholders and details the strategies for addressing suicidal ideation, self-harm, and suicide attempts among youth. The guide highlights psychotherapeutic models that have shown evidence of effectiveness in reducing one or more of the outcomes of suicidal ideation, self-harm (non-suicidal), self-harm (unknown intent), and completed suicides.^{75,89,93}

CDC. The CDC has created a comprehensive technical package of strategies that can be implemented by communities and states that include strengthening economic supports; strengthening access and delivery of suicide care; creating protective environments; promoting connectedness; teaching coping and problem-solving skills; identifying and supporting people at risk; and lessening harms and preventing future risk. Also, the CDC has recently released information showing the increased risk for suicide and negative opioid related outcomes (including overdose) associated with ACEs.^{33,62}

FEDERATION OF MEDICINE EFFORTS

Several medical specialty societies have addressed youth suicide. The American Academy of Pediatrics (AAP) has developed web-based downloadable targeted at teens and their parents/caretakers on mental health as well as identifying suicide risk and creating emotional well-being in teens and children.⁹⁴ Other societies including the American College of Emergency Physicians (ACEP), American Association of Family Physicians (AAFP), the American

Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) all have patient resources, policies, clinical guidance, or public statements addressing depression and identifying imminent risk for STB in youth and adults.^{50,94-97}

A 2021 joint summit on teen suicide co-hosted by the AAP, the American Foundation for Suicide Prevention (AFSP), and the National Institute for Mental Health (NIMH), brought forth several recommendations including the need for early identification of suicide risk, screening/assessment, follow up, and counseling. Other recommendations included the importance of widespread screening for youth seen in the ED for any reason and using a strengths-based and culturally sensitive approach to help youth disclose possible suicidal thoughts and ideation. A focus on prevention efforts, along with better data on their effectiveness for sub-populations (Black, Indigenous/Alaska natives, and LGBTQ youth) was also highlighted. A suicide prevention blueprint document from the summit is scheduled to be available later in 2021.⁹⁸

EMERGING AREAS OF RESEARCH

Medications

New medications for acute STB are being developed and experts have called for increased utilization of existing medications. Leading experts encourage continued research to understand the neurobiology of suicide, including the identification of biomarkers and neuropsychological vulnerabilities associated with acute suicidality.^{79,99} A better understanding of the neuropathophysiology of suicide can assist in the development of new medications for treatment.

Digital Technology and Machine Learning

The National Institutes of Health is funding research into the Mobile Assessment for the Prediction of Suicide (MAPS) as a way of using machine learning to detect suicide risk. These risk prediction algorithms can be embedded in digital devices such as smartphones, tablets, and laptops, and show promise in detection of near and imminent risk.¹⁰⁰

Imminent Risk-Warning Signs

One of the most significant challenges of reducing suicides in youth, as in all demographics, is detecting windows of acute and imminent risk. While many of the risk factors for suicide in young people are understood, the ability to predict imminent risk effectively is lacking. Signs of imminent risk include talking about wanting to die, asking how one will be remembered, seeking out means of suicide, talking about feeling hopeless, expressing feelings of being trapped in unbearable pain, increased misuse of alcohol or drugs, increased agitation, withdrawal, mood dysregulation, and giving away treasured items and belongings.^{19,69}

CONCLUSION

Suicides are increasing among both male and female adolescents, with males using more lethal means such as firearms in completed suicides and attempts. The young Native American/Alaska Native demographic group has the highest number of completed suicides and attempts among all youth. Increases in instances of cyberbullying are an important factor that are associated with youth suicide and require additional attention. Increases in screen time and use of digital devices, internet, and social networking sites have been associated with decreases in time sleeping and increased depression. Additionally, stress and disruption associated with the COVID-19 pandemic, such as physical distancing and isolation, have worsened mental health for all cohorts, including young

people and increased suicidal ideation in some cases. Importantly, evidence clearly notes that when co-occurring mental illness (depression, anxiety), SUD, ACEs, or other stressors are present, risk for STB increases.^{29,41,70}

Enhancing physician ability and capacity to screen, identify and respond to risk factors are an important feature of effective suicide prevention for youth, especially for those physicians who are more likely to encounter these patient populations. Physicians should have access to the tools to identify acute and imminent risk and respond with appropriate treatments, linkages to appropriate counseling services, collaboration, and safety planning. Collectively, parents, teachers, peers, physicians, social workers, faith communities, counselors, and others, are critical in identifying when an individual is experiencing a period of imminent risk and assisting in preventing suicide attempts.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That Policy H-60.937 be amended to read as follows:

~~Teen~~ Youth and Young Adult Suicide in the United States

Our AMA:

- (1) Recognizes ~~teen-youth~~ and young adult suicide as a serious health concern in the US;
- (2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
- (3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
- (4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
- (5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Latino, and Indigenous/Native Alaskan youth and young adult populations;
- (6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults; and

- 1 (7) Supports research to identify evidence-based universal and targeted suicide prevention
2 programs for implementation in middle schools and high schools. (Modify Current HOD
3 policy)
4
- 5 2. That Policy H-515-952, “Adverse Childhood Experiences and Trauma-Informed Care” be
6 amended by addition to read as follows:
7
- 8 1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread
9 impact of trauma on patients, identifies the signs and symptoms of trauma, and treats
10 patients by fully integrating knowledge about trauma into policies, procedures, and
11 practices and seeking to avoid re-traumatization.
12
- 13 2. Our AMA supports:
14 a. evidence-based primary prevention strategies for Adverse Childhood Experiences
15 (ACEs);
16 b. evidence-based trauma-informed care in all medical settings that focuses on the
17 prevention of poor health and life outcomes after ACEs or other trauma at any time in
18 life occurs;
19 c. efforts for data collection, research, and evaluation of cost-effective ACEs screening
20 tools without additional burden for physicians.
21 d. efforts to educate physicians about the facilitators, barriers and best practices for
22 providers implementing ACEs screening and trauma-informed care approaches into a
23 clinical setting; ~~and~~
24 e. funding for schools, behavioral and mental health services, professional groups,
25 community, and government agencies to support patients with ACEs or trauma at any
26 time in life; and
27 f. increased screening for ACEs in medical settings, in recognition of the intersectionality
28 of ACEs with significant increased risk for suicide, negative substance use-related
29 outcomes including overdose, and a multitude of downstream negative health
30 outcomes. (Modify Current HOD policy)
31
- 32 3. That Policy H-145.975, “Firearm Safety and Research, Reduction in Firearm Violence, and
33 Enhancing Access to Mental Health Care,” which recognizes the role of firearms in suicides;
34 encourages the development of curricula and training for physicians with a focus
35 on suicide risk assessment and prevention as well as lethal means safety counseling; and
36 encourages physicians, as a part of their suicide prevention strategy, to discuss lethal
37 means safety and work with families to reduce access to lethal means of suicide, be
38 reaffirmed. . (Reaffirm Current HOD Policy).
39
- 40 4. That Policy H-170.984, “Healthy Living Behaviors,” encouraging state medical societies and
41 physicians to promote physical and wellness activities for children and youth and to advocate
42 for health and wellness programs for children and youth in schools and communities, be
43 reaffirmed. (Reaffirm Current HOD Policy)

Fiscal note: Less than \$500

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 05-JUN-21

Subject: Medical Center Patient Transfer Policies
(Resolution 818-I-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Interim Meeting, the House of Delegates referred Resolution 818, which was sponsored by the Organized Medical Staff Section. Resolution 818-I-19 asked the American Medical Association (AMA) to: (1) study the impact of “auto accept” policies (i.e., unconditional acceptance for the care of a patient) on public health, as well as their compliance with the Emergency Medical Treatment and Labor Act (EMTALA) in order to protect the safety of our patients; and (2) advocate that if a medical center adopts an auto accept policy, it must have been ratified, as well as overseen and/or crafted, by the independent medical staff. Reference Committee J from the 2019 Interim Meeting noted that the resolution simultaneously called for study and new policy, and it emphasized the importance of first studying the issue of auto accept policies. Accordingly, this report explores patient transfer issues, with consideration of potential clinical and financial impacts on patients, and legal, accreditation, and medical staff bylaws implications for physicians and medical centers.

BACKGROUND

Optimal patient health and well-being should be the principal goals of patient transfer, but disagreements can arise in pursuing those goals. Some physicians have observed that medical centers where they practice can automatically accept the transfer of patients with emergent and/or serious conditions, and they have voiced concern that accepting transfer patients without adequate input from the medical staff could jeopardize patient care. The term “auto accept policies” encompasses a variety of medical center policies that address how patients may be “automatically” received at their institutions. For example, one large public health system has implemented an auto accept policy whereby critical care nurses answer phone calls from transferring physicians and accept patient transfers instantaneously--transfer requests are not denied.¹ As part of this system, physicians are paid to be on call and to receive patients from the region. Another medical center will automatically accept any acute critical transfer, with a specially educated triage registered nurse gathering clinical and basic demographic information, locating an accepting physician, and arranging for a bed in the appropriate level of care that will be ready when the patient arrives.² As a third example, another medical center has a pilot program to automatically accept into their Emergency Department (ED) stable patients from other medical centers who need specific services.³ These varied auto accept policies highlight the challenges that are inherent in transferring patients among medical centers and the critical role that physicians must play in these processes.

Any time a patient is transferred from one facility to another, it is essential that both transferring and receiving facilities ensure that there is an accepting physician who is capable of taking responsibility for the care of the transferred patient, and medical centers receiving a transferred patient must affirmatively accept the patient. Under certain conditions, acceptance will be

1 mandatory. Nevertheless, medical center transfer policies, including auto accept policies, that fail
2 to identify the appropriate physicians and their capabilities run the risk of suboptimal care for the
3 patient and delays while the appropriate physicians and resources are identified. In addition,
4 transfers of patients with emergent and/or serious conditions carry implications not only for
5 individual patients, but also public health and legal implications for individual physicians and
6 medical centers, so patient transfer policies must address all of these implications.

7 8 KEY CHALLENGES ARISING WITH PATIENT TRANSFERS

9
10 Interhospital transfer is an understudied area, with little known about institutional variations in
11 information transfer and impacts on patient outcomes.⁴ A recent survey of 32 tertiary care centers
12 in the United States studied communication and documentation practices during interhospital
13 patient transfers and found that practices vary widely among tertiary care centers, and the level of
14 transfer center involvement in oral and written handoff was inconsistent.⁵ Moreover, patients may
15 be transferred from one medical center to another for a variety of reasons, including to receive
16 specific expert medical services such as monitoring, tests, or procedures, or to accommodate
17 patient or family preference.⁶ With a variety of specialists involved in the care of patients with
18 emergent and/or serious conditions requiring transfer, communication and coordination are critical,
19 but complicated.⁷ Often, the physicians who will be directly caring for a transferred patient want to
20 be involved early in the transfer process to ensure that their specific questions are answered.⁸ In an
21 attempt to address transfer challenges, some hospitals have established dedicated call centers, often
22 staffed by senior-level nurses, to coordinate communication between accepting and receiving
23 physicians.⁹ However, studies have found such call centers to be highly variable in their
24 functionality and effectiveness.¹⁰

25
26 Non-medical factors have been found to influence decisions regarding whether a stable patient will
27 be transferred to another facility for inpatient care, but again, the impact on quality of care is
28 unknown. An analysis of all-payer administrative data from a representative sample of community
29 hospitals in the United States found that uninsured patients and women were significantly less
30 likely to be transferred to another acute care hospital.¹¹ The study authors were surprised to find the
31 lower rate of transfer for uninsured patients, expecting that a hospital would seek to transfer
32 uninsured patients as soon as they fulfilled their EMTALA obligations. Instead, the study authors
33 suspected that the lower transfer rates for uninsured patients can be explained by an unwillingness
34 of receiving hospitals to accept uninsured transfer patients. At the same time, the study authors
35 emphasized that economic factors are unlikely to explain the lower transfer rates they found for
36 women, and they expressed concern for the potential of implicit or explicit biases contributing to
37 this disparity. Critically, though, it is unknown whether the differences in transfer patterns
38 identified in this study led to differences in health outcomes.

39
40 Hospitals' interfacility transfer agreements and protocols can impact patient care not only within
41 inpatient departments, but in the ED as well. To the extent that inpatient beds are reserved for
42 specific categories of patients, including interfacility transfer patients, challenges can arise when
43 there are insufficient inpatient beds available to receive transfers from the medical center's ED.¹²
44 Patients who stay in the ED for longer than the time required for a "timely transfer" to an inpatient
45 bed are considered "boarders," and challenges surrounding boarding patients in the ED are well-
46 established.¹³ (Definitions of "timely transfer" vary, but experts often look for a period of less than
47 two hours from the admission order.) Boarding can exacerbate health disparities, with Black,
48 female, elderly, and psychiatric patients being more likely to board for longer periods of time.¹⁴
49 Moreover, patients with medically treated conditions are more likely to board than those with
50 surgically treated conditions.¹⁵ With the ED being the dominant source of hospital admissions,¹⁶ it
51 is critical for medical center transfer policies to promote optimal care for the patients who present

with emergent and/or serious conditions, both before and after their stabilization. The problems associated with patient boarding are so severe, there is evidence that they increase in-hospital death rates substantially.¹⁷ Reflecting these problems, The Joint Commission (TJC) imposes requirements that hospitals address boarding for purposes of accreditation.¹⁸ Importantly, reservation of inpatient beds for interfacility transfer patients is just one factor contributing to the complex challenge of ED boarding, and solving the broader issue of ED boarding is beyond the scope of this report.

When contemplating the transfer of a stable patient who is not receiving care in an ED, in addition to the critical clinical implications of the transfer, patient financial impacts must also be considered. Prior to transferring a patient to a new medical center, it is important to consider whether the new facility is in-network under the patient's health plan. If the intended transfer facility is out-of-network (OON), the patient and/or family will need to be prepared for the financial implications of receiving OON care. Additionally, if the patient is receiving, or intends to receive, care that requires prior authorization (PA), it is important to recognize that site of service can be an essential element of PA approval,¹⁹ so a service approved at an originating facility may require reapproval for a new site of service. Transfer decisions should include a patient-centered discussion between a patient and/or family and a referring physician that addresses the various potential merits and risks of undergoing a transfer.²⁰

The novel coronavirus (COVID-19) pandemic has posed unprecedented challenges, including managing patient transfers. Geographically localized surges in COVID-19 cases put extreme pressure on local health care facilities, as hospitals strive to transfer COVID-19 patients to sites where they can receive optimal care and/or transfer non-COVID-19 patients out of their facility to protect uninfected patients and free up resources to care for more COVID-19 patients.²¹ State and local emergency medical planners have taken a variety of approaches in rising to meet the pandemic's challenges, and the Centers for Disease Control and Prevention (CDC) has issued guidance around patient safety and relief for health care facility operations.²² The CDC emphasizes the importance of communication between health care professionals at both the transferring and receiving facilities with accurate clinical descriptions of patients and clear acceptance by receiving facilities.

Balancing the complex considerations surrounding patient transfers, the American College of Emergency Physicians (ACEP) has published guidelines on Appropriate Interfacility Patient Transfer, and AMA policy (Policies H-130.982 and H-130.961) expressly supports these guidelines. Key elements of the ACEP guidelines specify, "The medical facility's policies and procedures and/or medical staff bylaws must define who is responsible for accepting and transferring patients on behalf of the hospital . . . Agreement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of the transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a receiving facility with the capability and capacity to provide a higher level of care may not refuse any request for transfer. When transfer of patients is part of a regional plan to provide optimal care at a specialized medical facility, written transfer protocols and interfacility agreements should be in place."²³ These guidelines, developed by subject matter experts and supported by the AMA, help to ensure that high quality patient care drives interfacility patient transfers, with physician input into the decision-making process.

EXTERNAL FACTORS SHAPING PATIENT TRANSFER POLICIES

Medical centers' ability to implement transfer policies such as the auto accept policies described in Resolution 818-I-19 is influenced by a number of external factors, including Medicare Conditions of Participation (COPs), accreditation standards, medical staff governing documents, and in certain

1 cases, state and/or federal law. Medicare COPs govern patient transfer in the context of discharge
2 planning, requiring that hospitals transfer or refer patients to appropriate facilities, agencies, or
3 outpatient services, as needed, for follow-up or ancillary care.²⁴ Moreover, Medicare COPs make
4 clear that the medical staff “is responsible for the quality of medical care provided to patients by
5 the hospital,”²⁵ and TJC provides an accreditation framework to guide medical center and physician
6 collaboration. As outlined by TJC, “The organized medical staff oversees the quality of patient
7 care, treatment, and services provided by practitioners privileged through the medical staff
8 process.”²⁶ Additionally, for a medical center’s “governing body to effectively fulfill its
9 accountability for the safety and quality of care, it must work collaboratively with the medical staff
10 leaders toward that goal.”²⁷ While accreditation standards do not have the force of law, TJC’s long
11 history of hospital accreditation and its recognition by federal and private payers have made its
12 standards nationally accepted practices.²⁸ Additionally, medical staff documents including bylaws,
13 rules and regulations, and policies govern the relationship between medical centers and their
14 medical staff. The bylaws describe the rights, responsibilities, and accountabilities of the medical
15 staff and specify how the organized medical staff works with and is accountable to the governing
16 body. Medical staff rules and regulations usually address patient care issues across the organization
17 and typically contain provisions about patient transfers.²⁹

18
19 As the sponsors of Resolution 818-I-19 indicate, EMTALA provides a legal framework for many
20 interhospital transfers, with specific mandates for both facilities and physicians. EMTALA was
21 established as federal law in 1986, and many states have related laws and regulations that impose
22 additional duties on hospitals and physicians.³⁰ EMTALA was designed to prevent hospitals from
23 transferring uninsured or Medicaid patients to public hospitals without minimally providing a
24 medical screening examination to ensure the patients were stable for transfer. Additionally, under
25 EMTALA, hospitals with specialized capabilities must accept patient transfers from hospitals that
26 lack the capability to treat unstable emergency medical conditions, and EMTALA transfer
27 obligations apply, even under the extraordinary circumstances posed by COVID-19.³¹ However,
28 EMTALA does not apply to the transfer of stable patients. Importantly, both hospitals and
29 physicians can be penalized for EMTALA violations, with penalties including termination of the
30 hospital or physician’s Medicare provider agreement and fines of up to \$104,826 per violation.³²
31 With both the hospital and the physician individually liable under EMTALA, it is critical that both
32 work together to ensure that patient transfers further the shared goal of optimal patient care.

33 34 RELEVANT AMA POLICY

35
36 AMA policy directly responds to the resolves of referred Resolution 818-I-19. First, a
37 comprehensive array of policy guides collaboration between medical centers and medical staff.
38 Policy H-225.957 sets forth principles for strengthening the physician-hospital relationship,
39 emphasizing the interdependence between the organized medical staff and the hospital governing
40 body, while highlighting the medical staff’s role in quality-of-care issues. Similarly, Policy
41 H-225.971 provides a strong framework for how hospitals and medical staff ought to collaborate
42 and articulates the primary role of the medical staff on matters of quality of care and patient safety.
43 In addition, Policy H-225.942 provides a set of physician and medical staff member bill of rights,
44 which include the right to be well-informed and share in the decision-making of the health care
45 organization’s operational and strategic planning. Finally, Policy H-225.961 states that in crafting
46 medical staff development plans, hospitals/health systems should incorporate the principles that the
47 medical staff and its elected leaders must be involved in the hospital/health system’s leadership
48 function, including in developing operational plans, service design, resource allocation, and
49 organizational policies. The policy further insists that the medical staff must ensure that quality
50 patient care is not harmed by economic motivations.

Long-standing policy also guides the transfer of patients among medical centers. Policy H-130.982 provides principles to guide interfacility transfers of unstable emergency patients, detailing the critical roles of both the transferring and receiving physicians and endorsing ACEP's Appropriate Interfacility Patient Transfer guidelines. Similarly, Policy H-130.961 also endorses the ACEP guidelines, encouraging county medical societies and local hospitals to review and utilize the ACEP guidelines as they develop local transfer arrangements. In addition, Policy H-130.965 supports working with the American Hospital Association (AHA) to develop model agreements for appropriate patient transfer.

Finally, AMA policy and advocacy strive to protect patients and physicians facing burdens from health plan OON restrictions and PA requirements. Policy H-285.904 sets forth principles related to unanticipated OON care, and Policy H-320.939 details the AMA's position on PA and utilization management (UM) reform.

In addition to AMA policy, AMA ethics opinions also guide physicians and medical centers as they refine patient transfer policies. *Code of Medical Ethics* Opinion 9.5.1 guides the relationship between an organized medical staff and hospital and establishes that the core responsibilities of the organized medical staff are the promotion of patient safety and the quality of care.³³ Additionally, *Code of Medical Ethics* Opinion 9.4.2 provides a series of steps physicians should take if they become aware of or strongly suspect that conduct threatens patient welfare or otherwise appears to violate ethical or legal standards.³⁴

DISCUSSION

The Council thanks the sponsors of Resolution 818-I-19 for highlighting the critical intersection of medical center transfer policies with quality of care, public health, legal/regulatory, and medical staff concerns. Existing AMA policy lays the groundwork to protect patients and physicians in the context of patient transfers, and this policy can be expanded. First, the Council recommends amending Policy H-130.982, changing the title of the policy and broadening the language used, so that this long-standing policy guiding the transfer of emergency patients would apply to protect all transferred patients. Similarly, the Council recommends building upon the strong policy that establishes a physician and medical staff member bill of rights and outlines the rights and responsibilities of organized medical staff. Policy H-225.942 emphasizes the importance of physicians' treatment decisions remaining insulated from commercial or other motivations that could threaten high-quality patient care and the medical staff's responsibility to participate in the health care organization's operational and strategic planning to safeguard the interests of patients, the community, the health care organization, and the medical staff and its members. The policy also outlines medical staff rights, including the right to be well-informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, or close medical staff departments. The Council recommends amending Policy H-225.942 to articulate the medical staff's right to be well-informed and share in the decision-making regarding transferring patients into, out of, or within the health care organization. Additionally, the Council recommends amending Policy H-130.965 to support working with both the AHA and other interested parties to develop model agreements for appropriate patient transfer.

Finally, recognizing the significant patient, physician, and medical center time and talent involved in obtaining PA approval, the Council believes that when circumstances (such as the site of service) change, the PA process should support revisions to pending or existing approvals rather than require re-initiation of the PA request. In articulating the AMA's position on PA and UM reform, Policy H-320.939 emphasizes that the AMA will continue its widespread PA advocacy and

1 outreach, including promotion and/or adoption of the Prior Authorization and Utilization
 2 Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey
 3 and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA
 4 administrative burdens and improving patient access to care. Building upon this strong advocacy
 5 position, the Council recommends amending Policy H-320.939 by adding a new section four
 6 stating that health plans should minimize the burden on patients, physicians, and medical centers
 7 when updates must be made to previously approved and/or pending PA requests.

8
 9 The Council also recommends reaffirming several policies that address key concerns raised by
 10 Resolution 818-I-19. Speaking to physician and medical staff roles in decision-making regarding
 11 patient transfers, Policy H-225.957 provides principles for strengthening the physician-hospital
 12 relationship. Policy H-225.957 emphasizes that the primary responsibility for the quality of care
 13 rendered and for patient safety is vested with the organized medical staff and sets forth parameters
 14 for collaboration and dispute resolution between the medical staff and hospital governing body. In
 15 addition, Policy H-225.971 details the roles that medical staff and hospital governing bodies and
 16 management each and collectively play in quality of care and credentialing and reaffirms TJC
 17 standard that medical staffs have “overall responsibility for the quality of the professional services
 18 provided by individuals with clinical privileges.” Moreover, the policy states that hospital
 19 administrative personnel performing quality assurance and other quality activities related to patient
 20 care should report to and be accountable to the medical staff committee responsible for quality
 21 improvement activities. Reaffirming these policies underscores the AMA’s longstanding and
 22 continuing commitment to productive collaboration between physicians and medical centers in
 23 developing patient transfer practices that are focused on providing high-quality patient care.
 24 Finally, the Council recommends reaffirming Policy H-285.904, which sets forth principles to
 25 protect patients receiving unanticipated OON care. Policy H-285.904 states that patients must not
 26 be financially penalized for receiving unanticipated care from an OON provider; insurers must
 27 meet appropriate network adequacy standards that include adequate patient access to care,
 28 including access to hospital-based physician specialties; and patients who are seeking emergency
 29 care should be protected under the “prudent layperson” legal standard, without regard to PA or
 30 retrospective denial for services after emergency care is rendered.

31 32 RECOMMENDATIONS

33
 34 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
 35 818-I-19 and that the remainder of the report be filed:

- 36
37 1. That our American Medical Association (AMA) amend Policy H-130.982 by addition and
38 deletion as follows:

39 40 H-130.982 Interfacility Patient Transfers of Emergency Patients

41 Our AMA: (1) supports the following principles for the interfacility patient transfers of
 42 ~~emergency patients~~: (a) all physicians and health care facilities have an ethical obligation
 43 and moral responsibility to provide needed medical care to all emergency patients,
 44 regardless of their ability to pay; (b) an interfacility patient transfer of an unstabilized
 45 ~~emergency patient~~ should be undertaken only for appropriate medical purposes, i.e., when
 46 in the physician’s judgment it is in the patient’s best interest to receive needed medical
 47 ~~service~~ care at the receiving facility rather than the transferring facility; and (c) all
 48 interfacility patient transfers of emergency patients should be subject to the sound medical
 49 judgment and consent of both the transferring and receiving physicians to assure the safety
 50 and appropriateness of each proposed transfer; (2) urges ~~county medical societies~~ physician
 51 organizations to develop, in conjunction with their local hospitals, protocols and

- 1 interhospital transfer agreements addressing the issue of economically motivated transfers
2 of emergency patients in their communities. At a minimum, these protocols and
3 agreements should address the condition of the patients transferred, the responsibilities of
4 the transferring and accepting physicians and facilities, and the designation of appropriate
5 referral facilities. The American College of Emergency Physicians' Appropriate
6 Interfacility Patient Transfer should be reviewed in the development of such community
7 protocols and agreements; and (3) urges state medical associations to encourage and
8 provide assistance to physician organizations that are their county medical societies as they
9 developing such protocols and interhospital agreements with their local hospitals. (Modify
10 Current HOD Policy)
11
- 12 2. That our AMA amend subsection II(d) of Policy H-225.942 by addition and deletion as
13 follows:
14
15 d. The right to be well informed and share in the decision-making of the health care
16 organization's operational and strategic planning, including involvement in decisions to
17 grant exclusive contracts, ~~or~~ close medical staff departments, or to transfer patients into,
18 out of, or within the health care organization. (Modify Current HOD Policy)
19
- 20 3. That our AMA amend Policy H-130.965 by addition as follows:
21
22 Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the
23 basis of economics; (2) supports working with the American Hospital Association (AHA)
24 and other interested parties to develop model agreements for appropriate patient transfer;
25 and (3) supports continued work by the AMA and the AHA on the problem of providing
26 adequate financing for the care of these patients transferred. (Modify Current HOD Policy)
27
- 28 4. That our AMA amend Policy H-320.939 by addition of a fourth section as follows:
29
30 4. Our AMA advocates for health plans to minimize the burden on patients, physicians, and
31 medical centers when updates must be made to previously approved and/or pending prior
32 authorization requests. (Modify Current HOD Policy)
33
- 34 5. That our AMA reaffirm Policy H-225.957, which provides principles for strengthening the
35 physician-hospital relationship. Policy H-225.957 sets forth parameters for collaboration
36 and dispute resolution between the medical staff and the hospital governing body, and it
37 establishes that the primary responsibility for the quality of care rendered and for patient
38 safety is vested with the organized medical staff. (Reaffirm HOD Policy)
39
- 40 6. That our AMA reaffirm Policy H-225.971, which details the roles that medical staff and
41 hospital governing bodies and management each and collectively play in quality of care
42 and credentialing. Policy H-225.971 states that hospital administrative personnel
43 performing quality assurance and other quality activities related to patient care should
44 report to and be accountable to the medical staff committee responsible for quality
45 improvement activities. (Reaffirm HOD Policy)
46
- 47 7. That our AMA reaffirm Policy H-285.904, which sets forth principles related to
48 unanticipated out-of-network care. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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Appendix: Policies Recommended for Amendment or Reaffirmation

H-130.965 Refusal of Appropriate Patient Transfers

Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred. (Sub. Res. 155, I-89Reaffirmed: Sunset Report and Reaffirmation A-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed: CMS Rep. 01, A-20)

H-130.982 Transfer of Emergency Patients

Our AMA: (1) supports the following principles for the transfer of emergency patients: (a) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility transfer of an unstabilized emergency patient should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical service care at the receiving facility rather than the transferring facility; and (c) all interfacility transfers of emergency patients should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges county medical societies to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to their county medical societies as they develop such protocols and interhospital agreements with their local hospitals.

(CMS Rep. H, A-86Reaffirmed: BOT Rep. BB, A-90Reaffirmed: CMS Rep. F, I-92Reaffirmation A-00Reaffirmed: CMS Rep. 6, A-10Modified: CMS Rep. 01, A-20)

H-225.942 Physician and Medical Staff Member Bill of Rights

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:
Preamble

The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients. Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

- a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
- b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes.
- c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
- d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
- e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
- f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

- a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
- b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body.
- c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
- d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
- e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
- f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

- a. The responsibility to work collaboratively with other members and with the health care organization's administration to improve quality and safety.
- b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
- c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
- d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.
- e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
- f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each

member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

- a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
 - b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
 - c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization's administration or governing body.
 - d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
 - e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
 - f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.
- (BOT Rep. 09, A-17Modified: BOT Rep. 05, I-17Appended: Res. 715, A-18Reaffirmed: BOT Rep. 13, A-19)

H-225.957 Principles for Strengthening the Physician-Hospital Relationship

The following twelve principles are AMA policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.
3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.
4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.
5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self-govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self-governance, which include but are not limited to:

- a) Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
- b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
- c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
- d) Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
- e) Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.
- f) Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
- g) Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
- h) Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality-of-care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
- i) Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.
- j) The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.
- k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

- l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.
- m) Enforcing the organized medical staff bylaws, regulations and policies and procedures.
- n) Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.
- 7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.
- 8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.
- 9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.
- 10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.
- 11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.
- 12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.
(Res. 828, I-07Reaffirmed in lieu of Res. 730, A-09Modified: Res. 820, I-09Reaffirmed: Res. 725, A-10Reaffirmation A-12Reaffirmed: CMS Rep. 6, I-13)

H-225.971 Credentialing and the Quality-of-Care

It is the policy of the AMA: (1) that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care; (2) that hospital medical staff bylaws reaffirm The Joint Commission standard that medical staffs have "overall responsibility for the quality of the professional services provided by individuals with clinical privileges"; (3) that each hospital's quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff's overall responsibility for quality of medical care; (4) that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and credentialing of these individuals; (5) that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the

medical staff committee responsible for quality improvement activities; (6) that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws; (7) that the general processes and policies related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff; and (8) that any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital.

(BOT Rep. T, I-92Reaffirmed: CMS Rep. 10, A-03Modified: CMS Rep. 4, A-13)

H-285.904 Out-of-Network Care

1. Our AMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the “prudent layperson” legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g., the Gould Criteria) are not accounted for within a minimum coverage standard.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Res. 108, A-17 Reaffirmation: A-18 Appended: Res. 104, A-18 Reaffirmed in lieu of: Res. 225, I-18 Reaffirmation: A-19 Reaffirmed: Res. 210, A-19

H-320.939 Prior Authorization and Utilization Management Reform

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.

2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

CMS Rep. 08, A-17 Reaffirmation: I-17 Reaffirmed: Res. 711, A-18 Appended: Res. 812, I-18

Reaffirmed in lieu of: Res. 713, A-19 Reaffirmed: CMS Rep. 05, A-19 Reaffirmed: Res. 811, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 022
(JUN-21)

Introduced by: Michigan

Subject: Maternal Levels of Care Standards of Practice

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Severe maternal morbidity and maternal-infant mortality continue to be a serious
2 national public health and physician concern; and
3

4 Whereas, In the last five years the Centers for Disease Control and Prevention (CDC), the
5 American College of Obstetricians and Gynecologists (ACOG), the Society for Maternal Fetal
6 Medicine (SMFM) and the Joint Commission, supported by other national professional
7 organizations, have recommended the implementation of initiatives to reduce severe maternal
8 morbidity and avoid preventable pregnancy-related maternal deaths; and
9

10 Whereas, Several states and specific geographic areas where maternal care is provided have
11 implemented collaborative programs to ensure optimal care to pregnant women and decrease
12 or avoid inequality in maternal care, an issue that more severely affects minorities; and
13

14 Whereas, Maternity care with standardized and established levels of care appears conducive to
15 provide optimal obstetrical and perinatal care and improve clinical outcomes; and
16

17 Whereas, AMA policy on Home Deliveries (H-245.971) supports the American College of
18 Obstetricians and Gynecologists statement that "the safest setting for labor, delivery, and the
19 immediate post-partum period is in the hospital, or a birthing center within a hospital complex,
20 that meets standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG,
21 or in a freestanding birthing center that meets the standards of the Accreditation Association for
22 Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers";
23 and
24

25 Whereas, Due to the increasing demand in clinical care added by the COVID-19 pandemic this
26 resolution requires urgent attention; therefore be it

1 RESOLVED: That our American Medical Association amend existing policy D-420.993,
2 "Disparities in Maternal Mortality," by addition and deletion to read as follows:
3

4 Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the
5 issue of health disparities in maternal mortality and offer recommendations to address
6 existing disparities in the rates of maternal mortality in the United States; (2) will work
7 with the CDC, HHS, state and county health departments to decrease maternal
8 mortality rates in the US; (3) encourages and promotes to all state and county health
9 departments to develop a maternal mortality surveillance system; and (4) will
10 advocate for the adoption of national standards of practice by birthing centers across
11 the country to help improve maternal health; and (5) will work with stakeholders to
12 encourage research on identifying barriers and developing strategies toward the
13 implementation of evidence-based practices to prevent disease conditions that
14 contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in
15 racial and ethnic minorities. (Modify Current HOD Policy)

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

Received: 05/27/21

AUTHOR'S STATEMENT OF PRIORITY

As hospitals ramped up to care for patients with COVID-19 and scaled back on elective procedures per government mandates during the pandemic surges, many patients grew increasingly concerned about risks of exposure when receiving necessary care in hospitals. For obstetrical patients, protocols such as prohibiting or limiting the number of persons who could attend appointments or be present during labor and birth only escalated fears about COVID-19 and the ability to adhere to birthing plans. As a result, non-hospital options have received increased attention. The Association of Maternal and Child Health Organizations offered the following observation:

"Midwives around the country have reported an astronomical increase in inquiries from expecting families considering home birth. One midwife from New York who typically sees 40 patients per year said at one point in the early spring of 2020 she was receiving almost 40 calls a day to inquire about home birth."

It is critical to ensure renewed interest in birthing centers is aligned with greater adoption of national standards of care.

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9. Arizona perinatal trust voluntary certification program. <https://azperinatal.org/certification>.

10. Georgia General Assembly. 2017-2018 regular session-HB 909:health;designation of perinatal facilities; provisions. <http://www.legis.ga.gov/Legislation/en-US/display/20172018/HB/909>
11. Indiana General Assembly 2018 session. SenateBill360. <https://iga.in.gov/legislative/2018/bills/senate/360>
12. Texas Office of the Secretary of State, Department of state Health Services. Texas administrative code; Title 25, part 1, Chapter 133, subchapter K. [https://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=133&sch=K&rl=Y](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=133&sch=K&rl=Y)
13. Executive Summary: Reproductive services for women at high risk for maternal mortality workshop. February 11-12, 2019, Las Vegas. Am J Obstet Gynecol October 2019, 221(4) B2-5 . Kramer M R et al. Changing the conversation: applying a health equity framework to maternal mortality reviews. Am J Obstet Gynecol. December 2019. 609-616

RELEVANT AMA POLICY

Disparities in Maternal Mortality D-420.993

Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities. Citation: CSAPH Rep. 3, A-09; Appended: Res. 403, A-11; Appended: Res. 417, A-18

Infant Mortality D-245.994

1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers.
2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.

Citation: Res. 410, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Maternal and Child Health Care H-420.986

The AMA opposes any further decreases in funding levels for maternal and child health programs; encourages more efficient use of existing resources for maternal and child health programs; encourages the federal government to allocate additional resources for increased health planning and program evaluation within Maternal and Child Health Block Grants; and urges increased participation of physicians through advice and involvement in the implementation of block grants. Citation: (BOT. Rep. V, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmation A-15)

Home Deliveries H-245.971

Our AMA: (1) supports the recent American College of Obstetricians and Gynecologists (ACOG) statement that "the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers"; and (2) supports state legislation that helps ensure safe deliveries and healthy babies by acknowledging that the safest setting for labor, delivery and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the AAP and ACOG, or in a freestanding birthing center that

meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers.

Citation: Res. 205, A-08; Reaffirmed: BOT Rep. 09, A-18

Obstetrical Delivery in the Home or Outpatient Facility H-420.998

Our AMA (1) believes that obstetrical deliveries should be performed in properly licensed, accredited, equipped and staffed obstetrical units; (2) believes that obstetrical care should be provided by qualified and licensed personnel who function in an environment conducive to peer review; (3) believes that obstetrical facilities and their staff should recognize the wishes of women and their families within the bounds of sound obstetrical practice; and (4) encourages public education concerning the risks and benefits of various birth alternatives.

Citation: Res. 23, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 023
(JUN-21)

Introduced by: Young Physicians Section

Subject: Pandemic Ethics and the Duty of Care

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Physicians have a duty to care for individual patients and safeguard public health;
2 and
3

4 Whereas, Increased patient and public health needs during a pandemic increases the gravity of
5 this ethical obligation and duty of care of a physician; and
6

7 Whereas, Code of Medical Ethics Opinion 8.3 states this obligation “holds even in the face of
8 greater than usual risks to physicians’ own safety, health, or life;” and
9

10 Whereas, A physician may not decline to care for a patient solely based on the patient’s
11 infectious disease status. However, this duty to care is not absolute and must be balanced
12 against other factors - including the health of the public in times of a pandemic; and
13

14 Whereas, Physicians also have obligations to their own family members as well as represent a
15 scarce commodity in times of a pandemic and thus, the workforce must be protected to care for
16 the public’s health; and
17

18 Whereas, Code of Medical Ethics Opinion 8.3 further states “when providing care in a disaster
19 with its inherent dangers, physicians also have an obligation to evaluate the risks of providing
20 care to individual patients versus the need to be available to provide care in the future;” and
21

22 Whereas, Shortages in personal protective equipment (PPE) were common in the early stages
23 of the COVID-19 pandemic; and
24

25 Whereas, Physicians without access to adequate PPE were placed in the challenging position
26 of having to balance their strong commitment to care for patients with suspected or confirmed
27 COVID-19 against the probability that they may contract and further transmit COVID-19, and be
28 unable to treat other patients if infected as a result; and
29

30 Whereas, The risk posed to physicians by COVID-19 without adequate PPE exceeded a level
31 that health care institutions and policymakers should require or expect of them; and
32

33 Whereas, “AMA Code of Medical Ethics: Guidance in a Pandemic” states “Whether physicians
34 can ethically decline to provide care if PPE is not available depends on several considerations,
35 particularly the anticipated level of risk. In some instances, circumstances unique to the
36 individual physician, or other health care professional, may justify such a refusal—for example,
37 when a physician has underlying health conditions that put them at extremely high risk for a
38 poor outcome should they become infected;”¹ and

Whereas, While individual health conditions are one consideration for balancing individual versus professional obligations, other considerations include family considerations, availability of similarly-trained professionals, etc.; and

Whereas, The AMA Code of Medical Ethics does not definitively state that individual physicians are the best situated in making this determination for their personal and professional lives; and

Whereas, In contrast, the American College of Obstetricians and Gynecologists states “Although individual physicians, after careful consideration, may opt to provide care without adequate PPE, physicians are not ethically obligated to provide care to high-risk patients without protections in place. . .As the personal risk that physicians are asked to assume escalates, the balance of competing duties and obligations becomes inherently personal. Thus, there should be no social or economic pressure exerted on physicians to assume unreasonable levels of risk;”² therefore be it

RESOLVED, That our Council on Ethical and Judicial Affairs reconsider its guidance on pandemics, disaster response and preparedness in terms of the limits of professional duty of individual physicians, especially in light of the unique dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic. (Directive to Take Action)

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

Received: 06/05/21

AUTHOR’S STATEMENT OF PRIORITY

This resolution asks CEJA to review its guidance on pandemic ethics, specifically in the area in which a physician has the right to say “no” to putting their life and their health at risk for their patients. This is important in the midst of a worldwide pandemic that does not look to have an end in sight. Importantly, CEJA’s last guidance on the issue was updated in 2017, before COVID-19 and the accompanying PPE shortages changed how we thought about distribution of scarce resources. We feel this is high priority as it impacts all physicians, would be a “core activity,” calls for a new important action that is missing from current policy, and will have a positive impact. While one specialty organization (ACOG) has issued this guidance, it is largely missing from that of other specialty societies – who tend to rely on AMA guidance on this issue. More importantly, the profession as a whole deserves guidance on this. Therefore, we feel this is a top priority resolution.

References:

1. <https://www.ama-assn.org/delivering-care/ethics/ama-code-medical-ethics-guidance-pandemic>
2. <https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-ethics>

RELEVANT AMA POLICY**Code of Medical Ethics Opinion 8.3 Physicians' Responsibilities in Disaster Response & Preparedness**

Whether at the national, regional, or local level, responses to disasters require extensive involvement from physicians individually and collectively. Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This obligation holds even in the face of greater than usual risks to physicians' own safety, health, or life.

However, the physician workforce is not an unlimited resource. Therefore, when providing care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the risks of providing care to individual patients versus the need to be available to provide care in the future.

With respect to disaster, whether natural or manmade, individual physicians should:

(a) Take appropriate advance measures, including acquiring and maintaining appropriate knowledge and skills to ensure they are able to provide medical services when needed.

Collectively, physicians should:

(b) Provide medical expertise and work with others to develop public health policies that:

Are designed to improve the effectiveness and availability of medical services during a disaster

Are based on sound science

Are based on respect for patients

(c) Advocate for and participate in ethically sound research to inform policy decisions.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 024
(JUN-21)

Introduced by: Young Physicians Section

Subject: AMA Bylaws Language on AMA Young Physicians Section Governing
Council Eligibility

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, AMA Bylaw 7.5.1 Membership states “All active physician members of the AMA who
2 are not resident/fellow physicians, but who are under 40 years of age or are within the first 8
3 years of professional practice after residency and fellowship training programs, shall be
4 members of the Young Physicians Section”; and
5

6 Whereas, AMA Bylaw 7.5.2 Cessation of Eligibility, “If any officer or Governing Council member
7 ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term
8 for which elected, the term of such officer or member shall terminate and the position shall be
9 declared vacant. If any officer’s or member’s term would terminate prior to the conclusion of an
10 Annual Meeting, such officer or member shall be permitted to serve in office until the conclusion
11 of the Annual Meeting in the calendar year in which such officer or member ceases to meet the
12 membership requirements of Bylaw 7.5.1, as long as the officer or member remains an active
13 physician member of the AMA. The preceding provision shall not apply to the Chair-Elect.
14 Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair
15 shall be permitted to complete the term of office even if the Immediate Past Chair is unable to
16 continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the officer
17 remains an active physician member of the AMA”; and
18

19 Whereas, Based on AMA Bylaw 7.5.2, a YPS member could be eligible and elected to serve as
20 Chair-Elect but later be deemed ineligible to continue as Chair the following year; and
21

22 Whereas, In order to avoid a disruption in section leadership, an individual elected as Chair-
23 Elect should be allowed to move through the Chair and Immediate Past Chair positions even if
24 he or she no longer is considered a young physician under the section membership; and
25

26 Whereas, A modification of AMA Bylaw 7.5.2 would allow individuals elected as Chair-Elect
27 shall serve a three-year term, which will include one year as Chair-Elect, one year as Chair, and
28 one year as Immediate Past Chair, beginning at the conclusion of the Annual Meeting at which
29 he or she was elected; therefore be it

1 RESOLVED, That the American Medical Association amend AMA Bylaw 7.5.1, Membership, to
2 read as follows:

3
4 7.5.1 Membership. All active physician members of the AMA who are not
5 resident/fellow physicians, but who are under 40 years of age or are within the
6 first 8 years of professional practice after residency and fellowship training
7 programs, shall be members of the Young Physicians Section until December
8 31 of the year of their 40th birthday or December 31 of the eighth year following
9 the completion of their graduate medical education.

10
11 7.5.1.1 Membership shall be granted to any physician serving as Chair or
12 Chair-Elect of the YPS, so long as they fulfilled the requirements of
13 7.5.1 when they were elected to Chair-Elect, until their term as Chair
14 has expired. (Modify Bylaws); and be it further

15
16 RESOLVED, That the AMA amend AMA Bylaw 7.5.2, Cessation of Eligibility, to read as follows:

17
18 7.5.2 If any officer or Governing Council member ceases to meet the membership
19 requirements of Bylaw 7.5.1 prior to the expiration of the term for which
20 elected, they shall be permitted to complete the term of office even if they are
21 ~~the term of such officer or member shall terminate and the position shall be~~
22 ~~declared vacant. If any officer's or member's term would terminate prior to the~~
23 ~~conclusion of an Annual Meeting, such officer or member shall be permitted to~~
24 ~~serve in office until the conclusion of the Annual Meeting in the calendar year in~~
25 ~~which such officer or member ceases to meet the membership requirements of~~
26 ~~Bylaw 7.5.1, as long as the officer or member remains an active physician~~
27 ~~member of the AMA. The preceding provision shall not apply to the Chair-Elect.~~
28 ~~Notwithstanding the immediately preceding provision of this section, the Immediate Past~~
29 ~~Chair shall be permitted to complete the term of office even if the Immediate Past Chair~~
30 ~~is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long~~
31 ~~as the office remains an active physician member of the AMA. (Modify Bylaws)~~

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

Received: 06/05/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution follows-up on a year-long process involving the Speakers, CEJA, and CCB. A similar report was accepted at the November 2020 Special Meeting of the AMA House of Delegates and then withdrawn after an agreement with CCB to have a YPS/CCB joint meeting. We have had that meeting and this resolution is the result of that conversation. We feel it is timely and urgent as going even one election cycle without clarifying who is/is not eligible is potentially not democratic. Our Assembly has now voted twice in strong support of this concept and is hoping to make the case on why this wording is preferable to CCB Report 3 (June 2021), which is currently an item of business. We feel it would be more effective to have both CCB Report 3 and this resolution considered at the same time so that all perspectives on this issue are addressed simultaneously and with equal weight. Therefore, we feel this is a top priority resolution.

RELEVANT AMA POLICY

B-7.5.1 Membership.

All active physician members of the AMA who are not resident/fellow physicians, but who are under 40 years of age or are within the first 8 years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section.

B-7.5.2 Cessation of Eligibility.

If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If any officer's or member's term would terminate prior to the conclusion of an Annual Meeting, such officer or member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such officer or member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the officer or member remains an active physician member of the AMA. The preceding provision shall not apply to the Chair-Elect. Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair shall be permitted to complete the term of office even if the Immediate Past Chair is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the officer remains an active physician member of the AMA.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(JUN-21)

Introduced by: Texas

Subject: Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility

Referred to: Reference Committee A

1 Whereas, The purpose of contracts between physicians and health plans is to arrange for
2 physicians to provide medical services to health plan policy holders; and
3

4 Whereas, Health plans encourage patients to find a medical home through these contracts,
5 which helps keep down medical costs; and
6

7 Whereas, Many physicians have adopted telemedicine as another way to care for patients and
8 reduce costs; and
9

10 Whereas, Health plans have been reluctant to adopt telemedicine as a covered benefit, thus
11 refusing to pay physicians who use telemedicine; and
12

13 Whereas, Health plans recently have begun to offer telemedicine as a covered benefit, waiving
14 any patient responsibility if the patient uses the plan's preferred vendor (such as Teledoc), but
15 charging a copay or coinsurance for a telemedicine encounter with a contracted physician,
16 thereby offering a separate set of benefits for the same service based on who renders the
17 service; therefore be it
18

19 RESOLVED, That our American Medical Association adopt as policy that health plans in a
20 binding contract with a physician must apply the same level of benefits concerning patient
21 responsibility (copay, coinsurance) regardless of the contracted physician or provider rendering
22 the service (New HOD Policy); and be it further
23

24 RESOLVED, That our AMA take this issue to the Council on Legislature for national/state
25 statutory action. (Directive to Take Action)

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

Received: 05/20/21

AUTHOR'S STATEMENT OF PRIORITY

Texas feels this resolution is top priority due to the great increase in the use of telemedicine during Covid 19.

RELEVANT AMA POLICY

Tiered, Narrow, or Restricted Physician Networks D-285.972

Our AMA will:

- (1) seek to have third party payers disclose, in plain language, the criteria by which the carrier creates a tiered, narrow or restricted network;
- (2) monitor the development of tiered, narrow or restricted networks to ensure that they are not inappropriately driven by economic criteria by the plans and that patients are not caused health care access problems based on the potential for a limited number of specialists in the resulting network(s); and
- (3) seek legislation or regulation which prohibits the formation of networks based solely on economic criteria and ensures that, before health plans can establish new panel networks, physicians are informed of the criteria for participating in those networks, with sufficient advance time to permit them to satisfy the criteria.

Citation: Res. 806, I-06; Reaffirmed in lieu of Res. 729, A-08; Reaffirmation I-10; Reaffirmed in lieu of Res. 815, I-13; Reaffirmation A-14; Reaffirmed: CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmation: A-19

Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks H-450.941

1. Our AMA will collaborate with interested parties to develop quality initiatives that exclusively benefit patients, protect patient access, do not contain requirements that permit third party interference in the patient-physician relationship, and are consistent with AMA policy and Code of Medical Ethics, including Policy H-450.947, which establishes the AMA's Principles and Guidelines for Pay-for-Performance and Policy H-406.994, which establishes principles for organizations to follow when developing physician profiles, and that our AMA actively oppose any pay-for-performance program that does not meet all the principles set forth in Policy H-450.947.
2. Our AMA strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors.
3. Our AMA pledges an unshakable and uncompromising commitment to the welfare of our patients, the health of our nation and the primacy of the patient-physician relationship free from intrusion from third parties.
4. Because there are reports that pay-for-performance programs may pose more risks to patients than benefits, our AMA will prepare an annual report on the risks and benefits of pay-for-performance programs, in general and specifically the largest programs in the country including Medicare, for the House of Delegates over the next three years, beginning at the 2007 Interim Meeting. This report should clearly delineate between private pay-for-performance programs and voluntary public pay-for-reporting and other related quality initiatives.
5. Our AMA will continue to work with other medical and specialty associations to develop effective means of maintaining high quality medical care which may include physician accountability to robust, effective, fair peer review programs, and use of specialty-based clinical data registries.
6. As a step toward providing the Centers for Medicare and Medicaid Services (CMS) with data on special populations with higher health risk levels and developing variable incentives in achieving quality, our AMA will continue to work with CMS to encourage and support pilot projects, such as the Physician Quality Reporting Initiative (PQRI), by state and specialty medical societies that are developed collaboratively to demonstrate effective incentives for improving quality, cost-effectiveness, and appropriateness of care.
7. Our AMA will advocate that physicians be allowed to review and correct inaccuracies in their patient specific data well in advance of any public release, decreased payments, or forfeiture of opportunity for additional compensation.

Citation: BOT Rep. 18, A-07; Reaffirmed in lieu of Res. 729, A-08; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmation I-10; Reaffirmed in lieu of Res. 808, I-10; Reaffirmed in lieu of Res. 824, I-10; Reaffirmed: BOT Action in response to referred for decision Res. 816, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(JUN-21)

Introduced by: Texas

Subject: Caps on Insulin Copayments with Insurance

Referred to: Reference Committee A

1 Whereas, Diabetes affects over 10% of the population in the United States and is a leading
2 cause of death nationally; and
3

4 Whereas, The annual average medical cost per diabetic patient is \$13,240 with approximately
5 44% of expenditures stemming from prescription medications, including insulin; and
6

7 Whereas, From 2012 to 2016, the average point-of-sale price of insulin nearly doubled from 13
8 cents per unit to 25 cents per unit, translating to a daily cost increase from \$7.80 to \$15 for a
9 type 1 diabetic patient using an average amount of insulin (60 units per day); and
10

11 Whereas, One in four patients reported cost-related insulin underuse, including taking smaller
12 doses and skipping doses, which was independent of the patient's prescription drug coverage
13 plan; and
14

15 Whereas, Patients who report cost-related underuse were more likely to have poor glycemic
16 control, increasing their risk for complications such as hypertension, chronic kidney disease,
17 neuropathy, lower limb amputations, retinopathy, stroke, coronary heart disease, depression,
18 and cancer; and
19

20 Whereas, AMA does not have an explicit policy regarding insulin pricing for patients; and
21

22 Whereas, Our AMA has policy consistent with the principle of increasing access to prescription
23 medications including insulin for patients; and
24

25 Whereas, Some private insurance programs have shown the capability to offer a capped
26 copayment on insulin for their customers; therefore be it
27

28 RESOLVED, That our American Medical Association support limiting the copayments insured
29 patients pay per month for prescribed insulin. (New HOD Policy)

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

Received: 05/20/21

AUTHOR'S STATEMENT OF PRIORITY

The delegation leadership feels there is good policy at the AMA concerning the cost of insulin but no specific policy on the amount that patients might have to pay for the prescription. We feel our AMA should be an advocate for the patient in these situations.

References:

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10. [Cigna and Express Scripts Introduce Patient Assurance Program to Cap Out of Pocket Costs at \\$25 per 30-Day Insulin Prescription](#) (news release). Cigna. April 3, 2019.

RELEVANT AMA POLICY**Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980**

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:

- a. The arbitration process should be overseen by objective, independent entities;
- b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
- c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
- d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
- e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
- f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
- g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
- h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
- i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.

2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:

- a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
- b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
- c. The use of any international drug price index or average should preserve patient access to necessary medications;
- d. The use of any international drug price index or average should limit burdens on physician practices; and
- e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.

3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.

Citation: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

Insulin Affordability H-110.984

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.

Citation: CMS Rep. 07, A-18

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
 7. Our AMA supports legislation to shorten the exclusivity period for biologics.
 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
 10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
 11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
 12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
 13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
- Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the

development and pricing of generic prescription drugs.

4. Our AMA supports measures that increase price transparency for generic prescription drugs.

Citation: Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Cost of Prescription Drugs H-110.997

Our AMA:

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

Citation: BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98;

Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep. 3, I-00; Reaffirmed:

Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed:

BOT Rep. 14, A-18

Reducing Prescription Drug Prices D-110.993

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

Citation: (CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14)

Prescription Drug Prices and Medicare D-330.954

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.

2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.

3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Citation: Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed:

CMS Rep. 3, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 120
(JUN-21)

Introduced by: Texas

Subject: Postpartum Maternal Healthcare Coverage Under Children's Insurance

Referred to: Reference Committee A

1 Whereas, Perinatal depression is defined as a major or minor depressive disorder with a
2 depressive episode occurring during pregnancy or within the first year after childbirth; and
3

4 Whereas, One in seven women suffer from perinatal depression during the first year of
5 motherhood; and
6

7 Whereas, Estimated rates of depression among pregnant and postpartum women range from
8 10% to 25%, depending on socioeconomic status and additional risk factors; and
9

10 Whereas, Postpartum screening is important to maximize the health of mothers with newborns
11 as screening provides a significant opportunity to identify factors that can affect maternal health,
12 such as breastfeeding practices, family planning, and depression; and
13

14 Whereas, Untreated postpartum depression interferes with the mother's ability to care for her
15 newborn and can lead to problems with the child's physical, cognitive, and behavioral
16 development; and
17

18 Whereas, Regular monitoring and support during the first three months postpartum should be
19 required to optimize maternal mental health and reduce the risk of suicide, especially among
20 mothers with a history of psychiatric disorders; and
21

22 Whereas, Barriers prevent peripartum women from accessing postpartum depression screening
23 and care, such as financial and geographic barriers that limit access to health care, societal and
24 familial stigma, and lack of postpartum depression education and awareness; and
25

26 Whereas, The World Health Organization recommends mothers receive at least three visits
27 from time of delivery to six weeks postpartum, where each visit includes psychosocial support to
28 help prevent postpartum depression; and
29

30 Whereas, The American Academy of Pediatrics recommends screening for maternal-perinatal
31 depression during pediatric visits; and
32

33 Whereas, In 2016, the Centers for Medicare & Medicaid Services published best practices for
34 state Medicaid programs to cover maternal depression screening as part of the pediatric well-
35 child visit; and
36

37 Whereas, As of 2018, screening for perinatal depression during the pediatric well-child visit is a
38 covered benefit in 25 state Medicaid programs; and

- 1 Whereas, Insurance coverage greatly improves health outcomes for individuals and families
2 because they have access to preventive and screening services; therefore be it
3
4 RESOLVED, That our American Medical Association work with relevant stakeholders to
5 support coverage of and payment for postpartum maternal health care for at least 12 months
6 postpartum under the newborn child's health insurance plan, including Children's Medicaid and
7 Children's Health Insurance Program plans for women who are otherwise uninsured or ineligible
8 for Medicaid. (Directive to Take Action)

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

Received: 05/20/21

AUTHOR'S STATEMENT OF PRIORITY

One in seven women suffer from perinatal depression during the first year of motherhood; and the estimated rates of depression among pregnant and postpartum women range from 10% to 25%, depending on socioeconomic status and additional risk factors. Postpartum screening is important to maximize the health of mothers with newborns as screening provides a significant opportunity to identify factors that can affect maternal health, such as breastfeeding practices, family planning, and depression. Untreated postpartum depression interferes with the mother's ability to care for her newborn and can lead to problems with the child's physical, cognitive, and behavioral development.

This resolution would benefit mothers and newborns treated by primary care, pediatric, and psychiatric subspecialties. TMA is actively supporting related legislation but encourages the AMA House of Delegates to adopt it to address these issues with Employee Retirement Income Security Act (ERISA) plans that could be excluded by state-specific legislation.

Delegation leadership testified at the TMA reference committees that AMA has good policy which covers this resolution and AMA considers resolutions which are reaffirmation of current policy with little to no change as "Not a Priority Resolution" and probably will not be considered at the June 2021 Special Meeting. The TMA House of Delegates felt it should still be referred to the AMA because it is such an important issue.

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RELEVANT AMA POLICY**Extending Medicaid Coverage for One Year Postpartum D-290.974**

Our AMA will work with relevant stakeholders to support extension of Medicaid coverage to 12 months postpartum.

Citation: Res. 221, A-19

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953

Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.

Citation: Res. 102, A-12; Modified: Res. 503, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 121
(JUN-21)

Introduced by: Michigan

Subject: Medicaid Dialysis Policy for Undocumented Patients

Referred to: Reference Committee A

1 Whereas, In most states undocumented migrants with end stage kidney disease (ESKD) are
2 ineligible for public assistance and rely on sessions of emergency dialysis when symptoms
3 become intolerable; and
4

5 Whereas, In most states, undocumented migrants access to care is limited to safety-net
6 providers, including hospital Emergency Departments (EDs) that are required to provide
7 emergency care under federal Emergency Medical Treatment and Labor Act (EMTALA), and
8 then have to wait until their symptoms qualify for ED admission for care to be reimbursed by
9 emergency Medicaid program funding; and
10

11 Whereas, The five-year mortality rate on emergency dialysis is 14 times higher than standard
12 care, and costs up to \$400,000 per patient annually compared to \$100,000 in the outpatient
13 setting; and
14

15 Whereas, Undocumented ESKD patients are often younger with fewer comorbidities than other
16 ESKD patients, making them often ideal candidates for transplantation, but usually they cannot
17 qualify due to lack of insurance to cover the high cost of immunosuppressive therapy; and
18

19 Whereas, Caring for these patients exerts a toll on physicians resulting in signs of burnout
20 stemming from the feeling that they were being forced to provide substandard care; and
21

22 Whereas, Undocumented patients can purchase commercial plans at full price due to a
23 provision in the Affordable Care Act (ACA) forbidding companies from denying coverage based
24 on preexisting conditions; and
25

26 Whereas, Some states have allowed patients to automatically qualify for outpatient dialysis care
27 after presenting to a hospital; therefore be it
28

29 RESOLVED, That our American Medical Association work with the Centers for Medicare and
30 Medicaid Services and state Medicaid programs to develop a dialysis policy for undocumented
31 patients with end stage kidney disease as an emergency condition covered under Medicaid.
32 (Directive to Take Action)

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

Received: 05/27/21

AUTHOR'S STATEMENT OF PRIORITY

This is a timely issue that should be addressed promptly for physicians and underserved, low-income, undocumented patients. It is an access-to-care issue for many patients. As noted above, the impact from a lack of action is costly in terms of lives lost and the financial impact on the Medicaid budgets of states and the federal government.

RELEVANT AMA POLICY

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.

Citation: Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: A-19; Reaffirmation: I-19

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.

Citation: Sub. Res. 207, A-93; Reaffirmed BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-19; Reaffirmation: I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 122
(JUN-21)

Introduced by: Integrated Physician Practice Section

Subject: Developing Best Practices for Prospective Payment Models

Referred to: Reference Committee A

1 Whereas, The COVID-19 pandemic has reduced visits and revenues for all specialties,
2 especially primary care; and
3

4 Whereas, During the pandemic, as financial losses mounted in practices relying primarily on
5 fee-for-service payments, preliminary studies found that systems operating under full
6 prospective payment models and partial prospective payment models appear to have fared
7 better; and
8

9 Whereas, The reduction in fee for service payments is a threat to physician practice financial
10 sustainability; and
11

12 Whereas, The Centers for Medicare and Medicaid Services (CMS) has promulgated value-
13 based payment mechanisms and prospective payment models such as diagnosis-related
14 groups and global payments; however it has been difficult for physicians and health systems to
15 manage the tension between these models and effectively implement them; and
16

17 Whereas, Significant barriers to moving toward prospective payment persist, such as ensuring
18 correct attribution of patients to a particular physician, and
19

20 Whereas, Global capitation may not work well in health systems that enter into various contracts
21 to provide different contracted services to different patients, and
22

23 Whereas, Medicare Advantage patients benefit from physician access to and use of plan data
24 and more robust risk-adjusted budgets that allow physicians and health systems to develop
25 programs that improve care and decrease total expenditures; and
26

27 Whereas, CMS's method of setting the base in the prospective payment models is flawed
28 because it is based on a health system's own benchmark, thus disincentivizing highly efficient
29 systems to move toward prospective payment; and
30

31 Whereas, The COVID-19 pandemic has precipitated a change in health care delivery and
32 physician practice that creates opportunities to redesign physician practice and payment
33 models; and
34

35 Whereas, Prospective payment or some permutation of advance payment can be an effective
36 payment arrangement that may also help sustain health systems and physician practice; and
37

38 Whereas, Our AMA has the representative credibility and resources to design and advocate in
39 this process; therefore be it

1 RESOLVED, That our American Medical Association study and identify best practices for
 2 financially viable models for prospective payment health insurance, including but not limited to
 3 appropriately attributing and allocating patients to physicians, elucidating best practices for
 4 systems with multiple payment contracts, and determining benchmarks for adequate
 5 infrastructure, capital investment, and models that accommodate variations in existing systems
 6 and practices (Directive to Take Action); and be it further

7
 8 RESOLVED, That our AMA use recommendations generated by its research to actively
 9 advocate for expanded use and access to prospective payment models (Directive to Take
 10 Action)

Fiscal Note: Not yet determined

Received: 06/06/21

AUTHOR'S STATEMENT OF PRIORITY

Physician practices and health systems in a fee-for-service payment model suffered immense financial losses during 2020. Inversely, physicians and systems using prospective payment models were shielded or had some measure of protection from the financial ravages of COVID. Many barriers still exist to PPM. To help physicians succeed in PPM and to safeguard against further financial losses, the AMA should act now to develop best practices for prospective payment models.

RELEVANT AMA POLICY

Medicare Prospective Payment System for Skilled Nursing Facilities H-280.956

Our AMA: (1) advocates for the prospective payment systems being developed by CMS for skilled nursing facilities and home health agencies accurately reflect the costs of care for patients with multiple comorbidities and high medical complexity; and (2) advocates that CMS, the Medicare Payment Advisory Commission, and the Congress monitor the effects of the home health interim payment system and the new prospective payment systems on quality of care and patient access to medically necessary services.

Citation: Sub. Res. 108, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18

Prospective Payment System and DRGs for Physicians H-390.992

The AMA (1) endorses the concept that any system of reimbursement for physicians' services should be independent of reimbursement systems for other providers of health care; and (2) opposes expansion of prospective pricing systems until their impact on the quality, cost and access to medical care have been adequately evaluated.

Citation: Sub. Res. 70, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: A-05; Reaffirmed: I-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 123
(JUN-21)

Introduced by: Medical Student Section

Subject: Medicare Eligibility at Age 60

Referred to: Reference Committee A

1 Whereas, President Biden's 2020 campaign platform included a proposal to lower the eligibility
2 threshold to Medicare from age 65 to age 60¹⁻³; and
3

4 Whereas, Under Biden's proposal, qualifying individuals aged 60 to 64 would be granted the
5 choice to enroll either in Medicare or in any other public or private insurance plan for which they
6 are eligible¹⁻³; and
7

8 Whereas, Proposals to expand Medicare eligibility have existed as early as 1998, when
9 President Clinton proposed lowering the eligibility threshold to age 55⁴; and
10

11 Whereas, Proposals include either lowering the eligibility threshold to receive Medicare as a
12 federal entitlement, or offering the opportunity to purchase Medicare (a "buy-in" plan), with ages
13 62, 60, 55, and 50 commonly mentioned as possible thresholds for either type of proposal⁵; and
14

15 Whereas, According to a 2019 Kaiser Family Foundation (KFF) survey, a supermajority (77%)
16 of Americans regardless of partisan affiliation, including 85% of Democrats, 69% of
17 Republicans, and 75% of independents, support a Medicare "buy-in" proposal for individuals
18 aged 50 to 64, such that those individuals would then receive Medicare as a federal entitlement
19 at age 65⁶; and
20

21 Whereas, According to a Commonwealth Fund piece co-authored by the Biden Administration's
22 Director of the Center for Medicare & Medicaid Innovation (CMMI), legislation to lower
23 Medicare eligibility at age 60 would pass the "Byrd Rule" and be permissible under the budget
24 reconciliation, meaning that only a simple majority of the US Senate and US House would be
25 required to pass this expansion²⁵; and
26

27 Whereas, In 2017, 1.5 million Americans aged 60 to 64 were uninsured, comprising 7.4% of the
28 population in that age range⁵; and
29

30 Whereas, A 2020 analysis from Avalere found that lowering the Medicare eligibility age to 60
31 would extend health insurance coverage to 1.7 million previously-uninsured individuals, and
32 expand Medicare eligibility to 3.8 million individuals with Medicaid coverage⁸; and
33

34 Whereas, Two new Kaiser Family Foundation analyses conclude that lowering the Medicare
35 eligibility to age 60 would likely reduce national health expenditures for those aged 60-64 and
36 decrease employer-sponsored health insurance premiums for those younger than 60, as the 60-
37 64 age band represents the highest-cost group of enrollees on private coverage²²⁻²³; and

1 Whereas, A *JAMA* May 2020 Viewpoint observed that “lowering the Medicare eligibility age to
2 60 years would achieve meaningful coverage gains while disrupting commercial insurance less
3 than would a broader public option or Medicare-for-All program”⁷; and
4

5 Whereas, For patients aged 60-64 currently enrolled in Medicaid, expanding Medicare eligibility
6 for this group would make them dually-eligible for both Medicaid and Medicare, reducing state
7 expenditures and relieving fiscal pressures on state budgets^{5,7}; and
8

9 Whereas, State budgets have come under intense pressure during the COVID-19 pandemic
10 due to issues such as surging Medicaid enrollment, particularly because older Medicaid
11 beneficiaries tend to have more serious conditions that require more healthcare services^{5,7}; and
12

13 Whereas, A pair of seminal 2007 studies comparing previously uninsured with previously
14 insured patients demonstrated that Medicare eligibility at age 65 was associated with significant
15 increases in physician visits and hospitalizations and improvements in general health, mobility,
16 agility, and cardiovascular outcomes for those with heart disease and diabetes, suggesting that
17 the “costs of expanding health insurance coverage for uninsured adults before they reach the
18 age of 65 years may be partially offset by subsequent reductions in healthcare use and
19 spending for these adults after the age of 65”¹¹⁻¹²; and
20

21 Whereas, Another pair of seminal 2008-2009 studies demonstrated that Medicare eligibility at
22 age 65 was again associated with a significant increase in physician visits, hospitalizations, and
23 elective procedures (such as gastric bypass and hip and knee replacement), and for emergency
24 department visits, significant reductions in 7-day, 28-day, and 1-year mortality, indicating that
25 Medicare eligibility had an immediate impact on survival in the first week to year of enrollment<sup>28-
26 29</sup>; and
27

28 Whereas, A 2020 analysis from Avalere found that lowering the Medicare eligibility age to 60
29 would extend health insurance coverage to 1.7 million previously-uninsured individuals, and
30 expand Medicare eligibility to 3.8 million individuals with Medicaid coverage⁸; and
31

32 Whereas, A 2017 study in *Annals of Surgery* found a 9.6% increase in post-discharge
33 rehabilitation use in trauma patients aged 65 versus those aged 64 and concluded that this was
34 specifically a result of Medicare eligibility, representing a profound increase in access to a
35 critical healthcare service strongly associated with improved functional outcomes following
36 trauma⁹; and
37

38 Whereas, A 2020 study on lung, colon, and breast cancer (for all of which screening is
39 recommended starting before age 65) demonstrated a significant increase in detection after
40 reaching Medicare eligibility, as well as a significant reduction in mortality among women and an
41 even greater reduction for Black women, none of which were seen in a comparison population
42 of Canadians, suggesting that these changes are unique to US Medicare¹⁰; and
43

44 Whereas, A 2021 study of over 600,000 patients with lung, colon, breast, and prostate cancer
45 (for all of which screening is recommended starting before age 65) also demonstrated a
46 significant increase in detection, particularly of stage I cancers, and reduction in mortality for all
47 cancers after reaching Medicare eligibility, suggesting that waiting until age 65 may delay
48 necessary care²⁶; and

1 Whereas, A 2018 study of over 17,000 patients at all NIH-funded Alzheimer's Disease Research
2 Centers across the US demonstrated significant reductions in Clinical Dementia Rating and
3 Geriatric Depression Scale scores and estimated cost savings to patients of over \$9,000 in the
4 first year of eligibility and over \$1,000 each year after due to the decreased need for dependent
5 living²⁷; and
6

7 Whereas, When an individual who has employer-sponsored health insurance becomes eligible
8 for Medicare, they can enroll in Part A (premium-free for anyone paying Medicare taxes for at
9 least 10 years) to cover any hospitalization that may occur, protecting them from the most
10 expensive costs they might otherwise incur, and still keep their employer insurance (and delay
11 Part B) to cover any additional hospitalization expenses not paid by Medicare and to cover any
12 outpatient care, maintaining patient freedom to decide how much public or private coverage
13 they desire and fair reimbursement for physicians²⁴; and
14

15 Whereas, Medicare beneficiaries are less likely to report burdensome medical bills compared to
16 people under 65 with employer-sponsored or individual health insurance plans 13-14 ; and
17 Whereas, While the average retirement age in the US has steadily increased over time, the
18 2016 average age was 64.6 for men and 62.3 for women, both earlier than the full retirement
19 age (FRA) set by the Social Security Administration at 65 to 67 (depending on birth year)¹⁵⁻¹⁸;
20 and
21

22 Whereas, Based on the Census Bureau's Current Population Survey, disparities exist in the
23 average retirement age based on educational attainment, as the 2016 average age for male
24 college graduates is 65.7, but the average for male high school graduates is 62.3, and
25 furthermore illness is a major reason for early retirement in this latter group¹⁸; and
26

27 Whereas, The 2020 KFF Employer Health Benefits Survey found that only 29% of "large"
28 employers (those with 200 or more employees) extend employer-sponsored health benefits to
29 retirees, which included 66% of large public sector employers, but only 23% of large private
30 nonprofit employers and just 21% of large private for-profit employers, suggesting that
31 disparities in access to retiree health benefits exist based on sector of employment¹⁹; and
32

33 Whereas, The KFF Employer Health Benefits Survey also found that large employers with many
34 lower-wage employees (paid \$26,000 or less annually) are less likely to provide retiree health
35 benefits than large employers with many higher-wage employees (paid \$64,000 or more
36 annually), suggesting that disparities in access to retiree health benefits exist based on wages¹⁹;
37 and
38

39 Whereas, President Biden's proposal is specifically targeted at those "Americans who work hard
40 and retire before they turn 65" (when they would be eligible for Medicare currently) and those
41 who are nearing retirement²; and
42

43 Whereas, The Social Security Administration allows qualifying individuals to begin receiving
44 partial retirement benefits at age 62, the "early eligibility age" (EEA)^{15,20}; and
45

46 Whereas, Our AMA already supports "restructuring age-eligibility requirements and incentives
47 [of Medicare] to match the Social Security schedule of benefits"²; therefore be it
48

49 RESOLVED, That our American Medical Association advocate that the eligibility threshold to
50 receive Medicare as a federal entitlement be lowered from age 65 to age 60. (Directive to Take
51 Action)

Fiscal Note: Not yet determined

Received: 06/06/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be considered a priority at the June 2021 meeting due to active legislative discussion and its potential impact on countless people in the United States.

Policymakers are currently debating at this moment how best to introduce this in Congress, with many previously considering including this in the recently passed American Rescue Plan and now in the American Jobs Plan, the new infrastructure bill. Because this policy is currently permitted under budget reconciliation by the Byrd Rule, both chambers of Congress hold the power to pass this under a simple majority. However, this is only true until January 2023 (just 18 months after the J-21 Special Meeting), when the same party may no longer hold both chambers. **Our AMA's urgent consideration of this policy is vital if we want to be in this debate.** Given the AMA's essential and irreplaceable role in health reform, AMA support could itself be the catalyzing tipping point that urges Congress to introduce and pass this policy in the next 18 months, if we wish to support it. At N-20, AMA CMS and many delegates expressed the necessity of passing the public option report, just after the election and prior to the new Congress. An AMA debate over Medicare eligibility at age 60 is even more necessary, given its permissibility under budget reconciliation and the narrow 18-month advocacy window.

RELEVANT AMA POLICY

Strategies to Strengthen the Medicare Program H-330.896

Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate: 1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services should also be encouraged.

Simultaneously, policymakers will need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure. 2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard-setting and regulatory oversight of plans. 3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits.

CMS Rep. 10, A-07Reaffirmed: CMS Rep. 5, I-12Modified: Res. 508, A-14

Universal Health Coverage H-165.904

Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans

Sub. Res. 138, A-94Appended: Sub. Res. 109, I-98Reaffirmation A-02Reaffirmation A-07Reaffirmation I-07Reaffirmed: Res. 239, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(JUN-21)

Introduced by: Texas

Subject: Insurance Coverage Transparency

Referred to: Reference Committee B

1 Whereas, Medical offices and facilities want to provide accurate estimates of cost-sharing
2 liability to patients prior to office visits, procedures, and tests; and
3

4 Whereas, Medical offices and facilities often are unable to provide such estimates because
5 each commercial health insurance plan has its own rules regarding patient responsibility for
6 deductibles, copays, or coinsurance; and
7

8 Whereas, When medical offices and facilities call the insurance carrier or check online to verify
9 coverage, they frequently receive inaccurate information regarding the patient's cost-sharing
10 liability; and
11

12 Whereas, This inaccurate information can harm the patient-physician relationship if the
13 insurance carrier underestimates the patient's liability; and
14

15 Whereas, This inaccurate information also can delay medical care if the insurance carrier
16 overestimates the patient's liability, making the patient reluctant to proceed with recommended
17 tests or procedures; and
18

19 Whereas, Commercial insurance carriers have the technology to input the diagnosis and CPT
20 codes to immediately determine the patient's liability, they rarely provide this information to
21 medical offices and facilities; therefore be it
22

23 RESOLVED, That our American Medical Association advocate for legislation that requires
24 commercial insurance carriers to provide accurate information regarding the patient's cost-
25 sharing liability and the insurance plan's liability when a medical office or facility provides the
26 diagnosis and CPT codes via phone or the internet (Directive to Take Action); and be it further
27

28 RESOLVED, That our AMA advocate for legislation that requires commercial insurance carriers,
29 during insurance eligibility verification, to provide information regarding factors that may result in
30 denial of the claim, e.g., the insurance carrier is waiting for the primary policyholder to verify
31 whether he or she has other health insurance coverage (Directive to Take Action); and be it
32 further
33

34 RESOLVED, That our AMA advocate for legislation that requires commercial insurance carriers
35 to respond to telephone inquiries about the patient's cost-sharing liability by providing accurate
36 information verbally and via fax confirmation (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA advocate for legislation that penalizes commercial insurance
- 2 carriers, via fines and the publication of each carrier's number of noncompliance complaints,
- 3 when the above information is inaccurate or not provided in a timely manner. (Directive to Take
- 4 Action)

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

Received: 05/20/21

AUTHOR'S STATEMENT OF PRIORITY

Delegation leadership testified at the TMA reference committees that AMA has good policy which covers this resolution and AMA considers resolutions which are reaffirmation of current policy with little to no change as "Not a Priority Resolution" and probably will not be considered at the June 2021 Special Meeting. The TMA House of Delegates felt it should still be referred to the AMA because it is such an important issue.

RELEVANT AMA POLICY

Health Insurance Exchange and 90-Day Grace Period H-185.938

1. Our AMA opposes the preemption of state law by federal laws relating to the federal grace period for subsidized health benefit exchange enrollees, and will seek appropriate changes to federal law and regulations to protect state and prompt payment laws.
2. Our AMA will advocate that health plans be required to notify physicians that a patient is in the federal grace period for subsidized health benefit exchange enrollees upon an eligibility verification check by the physician. The notification must specify which month of the grace period a patient is in. Failure to notify physicians of patient grace period status would result in a binding eligibility determination upon the insurer.
3. Our AMA will continue to advocate that plans be required to pay providers for all claims for services rendered that would otherwise be covered under the contract during a grace period.
4. Our AMA will take all possible means available to change the current federal rule permitting the pending of claims during the grace period.
5. Our AMA will vigorously support state societies in their legal attempts to enforce prompt pay statutes and rules during grace periods.
6. Our AMA supports the development of alternative financing solutions, such as reinsurance for unpaid premiums, for physician payments during the grace period.

Citation: (Sub. Res. 813, I-13; Modified: Res. 707, A-14; Reaffirmation I-15)

Third Party Responsibility for Payment H-185.981

Our AMA (1) will develop, with the assistance of the Blue Cross and Blue Shield Association, the Group Health Association of America, the Health Insurance Association of America, and other relevant health care organizations, guidelines for a standardized system of verifying eligibility for health benefits; (2) will assume a leadership role with these organizations in the development of guidelines for a standardized system of verifying eligibility for health benefits; and (3) following the development of such guidelines, will work with major insurers and managed care plans to promote the development of a standardized, national health benefits verification system based on the guidelines, which would include an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously.

Citation: (Sub. Res. 721, A-92; Reaffirmed: Sub. Res. 828, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Sub. Res. 813, I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(JUN-21)

Introduced by: Michigan

Subject: Interest-Based Debt Burden on Medical Students and Residents

Referred to: Reference Committee B

1 Whereas, In 2017, 73 percent of medical students graduated with debt; and

2
3 Whereas, In the United States, the average medical school loan debt in 2017 was \$192,000, as
4 opposed to \$50,000 in 1992, representing a 220 percent increase in debt; and

5
6 Whereas, Subsidized, interest free loans were previously available prior to the 2011-2012
7 academic year for up to \$34,000 dollars, but are no longer available to medical students; and

8
9 Whereas, Stafford unsubsidized loans prior to 2006 had an interest rate of 1.87 percent while in
10 medical school to a current fixed and capitalizing rate of 6.8 percent; and

11
12 Whereas, The current interest rate on Graduate Plus Loans, used to supplement the cost of
13 medical education outside the Stafford loan has a fixed interest rate of 7.9 percent; and

14
15 Whereas, Medical school debt is negatively associated with mental well-being, and academic
16 outcomes, as well as an association with seeking higher paying specialties as opposed to
17 primary care; and

18
19 Whereas, The AMA recognizes the shortage of physicians across specialties, including primary
20 care, and has explored other innovative solutions to the recognized shortage; and

21
22 Whereas, The funding for graduate medical education has not increased consistent with the
23 number of medical school graduates, creating further financial risk for medical students; and

24
25 Whereas, The bipartisan H.R. 1554, "The Resident Education Deferred Interest Act," introduced
26 during the 116th Congress (2019-2020) sought to make interest free deferment on loans during
27 medical or dental internships or residency; and

28
29 Whereas, AMA policy supports advocacy for legislation and regulation that would lead to more
30 favorable terms and conditions for borrowing and loan repayment, as well as the self-managed
31 low interest loan programs; and

32
33 Whereas, The AMA supports taking an active role in the reauthorization of the Higher Education
34 Act, and similar legislations to expanding loan deferment and other concerns regarding medical
35 school debt; and

36
37 Whereas, AMA policy states the AMA will collaborate to advocate for reduction of Stafford and
38 Graduate Plus Loan program interest rates; therefore be it

- 1 RESOLVED, That our American Medical Association strongly advocate for the passage of
- 2 legislation to allow borrowers to qualify for interest-free deferment on their student loans while
- 3 serving in a medical or dental internship, residency, or fellowship program, as well as permitting
- 4 the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status
- 5 for the duration of undergraduate and graduate medical education. (Directive to Take Action)

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

Received: 05/27/21

The topic of this resolution is currently under study by the Council on Medical Education.

AUTHOR'S STATEMENT OF PRIORITY

The AMA has advocated that residents and medical students should be included in federal COVID-19 relief packages citing the critical role they have played in responding to the pandemic, as well as the added stress as their training has been disrupted. Providing financial relief in the form of interest-free deferments on student loans would lessen some of the financial strain weighing on residents and students during these difficult times.

Sources:

1. Youngclaus J. An Exploration of the Recent Decline in the Percentage of U.S. Medical School Graduates with Education Debt. AAMC Anal Br. 2018;1(4).
2. Pisaniello MS, Asahina AT, Bacchi S, et al. Effect of medical student debt on mental health, academic performance and specialty choice: A systematic review. BMJ Open. 2019;9(7):1-15. doi:10.1136/bmjopen-2019-029980
3. Craft JA, Craft TP. Rising medical education debt a mounting concern. Graduates also face less favorable repayment terms, shortage of training positions. Mo Med. 2012.
4. Babin B, Harris A, Posey B, Gosar P, Stivers S. Resident Education Deferred Interest Act. Washington D.C.: United States House of Representatives; 2019. <https://www.congress.gov/bills/116th-congress/house-bill/1554/all-info>.

RELEVANT AMA POLICY

Reduction in Student Loan Interest Rates D-305.984

1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.
 2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.
 3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
 4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
 5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.
- Citation: Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: 301, A-16

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.

2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan

Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(JUN-21)

Introduced by: Integrated Physician Practice Section

Subject: Audio-Only Telehealth for Risk Adjusted Payment Models

Referred to: Reference Committee B

Whereas, Telehealth services, including audio-only, have expanded dramatically during the COVID-19 Public Health Emergency (PHE) and now remain central to continuity of care while the Centers for Medicare and Medicaid Services (CMS) estimates up to 30% of visits during the pandemic have been audio-only¹; and

Whereas, Audio-only telehealth services have been critical to delivering healthcare to the underserved, and thus limiting audio-only telehealth services exacerbates health inequities. According to one study, during the pandemic, federally qualified health center audio-only visits accounted for 65.4% for all primary care visits and 71.6% of behavior health visits²; while another found that patients of all ages, races, payment types, and geographical locations accessed care using a telephone only³; and

Whereas, In 2018, the Federal Communications Commission (FCC) estimated that one-quarter of rural Americans—and one-third of Americans living on tribal lands—did not have access to broadband. Due to the lack of broadband availability, tens of millions of rural Americans aren't able to "see" their doctor during a telehealth visit⁴; and

Whereas, Lack of access to broadband services in underserved settings both urban and rural may result in audio-only care for patients with complex medical problems that may not be considered for risk adjustment; and

Whereas, While Medicare Advantage has allowed both audio and audio/video telehealth services, audio-only has not been allowed for risk adjustment, which impairs appropriate funding for health care delivery to the most vulnerable; and

Whereas, Our AMA has existing policy that states "telemedicine services should be covered and paid for" under appropriate circumstances (H-480.946), "support and advocate with all payers the right of physicians to obtain payment for telephone calls not covered by payments for other services" (H-390.889), as well as support of the "use of telehealth to reduce health disparities and promote access to health care" and "equitable coverage that allows patients to access telehealth services wherever they are located" (D-480.963), there is not specific policy to allow audio-only telehealth services to be used for diagnosis submission in risk adjusted models outside of a fee-for-service system; therefore be it

¹ Verma, S. Early Impact of CMS Expansion of Medicare Telehealth During COVID-19. Health Affairs Blog 2020. <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>

² Uscher-Pines L, et al. Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic. JAMA. 2021;325(11):1106-1107.

³ Koma, W., Cubanski, J. & Neuman, T. Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future. Kaiser Family Foundation. May 19, 2021. Accessed on May 19: <https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future/>

⁴ Federal Communications Commission, FCC 18-181, December 12, 2018. Accessed: <https://docs.fcc.gov/public/attachments/FCC-18-181A1.pdf>

- 1 RESOLVED, That our American Medical Association advocate that audio-only telehealth
2 encounter diagnoses be included in risk adjusted payment models. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 06/06/21

AUTHOR'S STATEMENT OF PRIORITY

AMA advocacy staff speculate that the best hope for Congressional action on important Medicare payment decisions related to telehealth will be through a legislative mega-package at the end of September or calendar year. Either way, the legislative language is being drafted now and it is important for the HOD to establish the proposed new policies to help guide AMA advocacy. The request for the AMA to advocate specifically for audio-only telehealth for purposes of determining patient risk in risk adjusted payment models, is a distinct area of focus not covered under existing telehealth policy. All physicians participating in Medicare Advantage and other risk-adjusted models are impacted by this issue.

RELEVANT AMA POLICY

Medicare Reimbursement of Telephone Consultations H-390.889

It is the policy of the AMA to: (1) support and advocate with all payers the right of physicians to obtain payment for telephone calls not covered by payments for other services; (2) continue to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services; (3) continue to work with CMS, other third party payers and appropriate medical specialty societies to establish the criteria by which certain telephone calls would be considered separate services for payment purposes; (4) request the CPT Editorial Panel to identify or consider developing the additional service code modifiers that may be required to certify specific types of telephone calls as separate from other services; and (5) seek enactment of legislation as needed to allow separate Medicare payment for those telephone calls that can be considered discrete and medically necessary services performed for the patient without his/her presence.

Citation: CMS Rep. N, A-92; Reaffirmed: Res. 122, I-97; Reaffirmed: A-99; Reaffirmed: I-99; Reaffirmed: A-01; Reaffirmed: A-07; Reaffirmed in lieu of Res. 824, I-11

Coverage of and Payment for Telemedicine H-480.946

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

- a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
 - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
 - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
 - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.

c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.

d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

e) The delivery of telemedicine services must be consistent with state scope of practice laws.

f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.

g) The standards and scope of telemedicine services should be consistent with related in-person services.

h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.

i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.

j) The patient's medical history must be collected as part of the provision of any telemedicine service.

k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.

l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.

m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.

4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.

5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.

6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

Citation: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CMS Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmed: A-18; Reaffirmed: CMS Rep. 1, I-19

COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963

Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

Citation: Alt. Res. 203, I-20

Improving Risk Adjustment in Alternative Payment Models H-385.907

Our AMA supports: (1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications; (2) risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost; (3) risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost; (4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control; (5) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and (6) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy.

Citation: CMS Rep. 03, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: COVID-19 Vaccination Rollout to Emergency Departments and Urgent Care Facilities

Referred to: Reference Committee B

1 Whereas, The vaccination rollout has marginalized some of our nation's most vulnerable
2 populations¹; and
3

4 Whereas, The AMA has recognized the utility of advocating for the vaccine to be in the hands of
5 physician offices²; and
6

7 Whereas, Emergency departments (EDs) disproportionately see high rates of patients who are
8 poor, elderly, individuals of color, immigrants, patients with disabilities, and patients with
9 significant comorbidities³; and
10

11 Whereas, EDs and urgent cares (UCs) already handle vaccination programs successfully such
12 as the annual influenza vaccine and the Tdap vaccine; and
13

14 Whereas, EDs and UCs have the capacity to deal with short observations after vaccine
15 administrations and are equipped to acutely treat allergic reactions if they occur; and
16

17 Whereas, Allowing the vaccine to be in the hands of physicians in the ED and UC settings
18 allows physicians to actively engage vaccine-hesitant patients and provide them with accurate
19 information; and
20

21 Whereas, A recent focus group highlighted that “doctors are far better messengers than
22 politicians, celebrities, or the media” when it comes the personal decision of getting the vaccine
23 or not and maybe one of the only ways to significantly change the minds of the vaccine
24 hesitant⁴; and
25

26 Whereas, The current Administration has acknowledged the need to “meet people where they
27 are” and have begun to distribute vaccines to places such as dialysis centers that
28 disproportionately serve vulnerable populations, but have yet to acknowledge the need to
29 distribute to EDs and UCs⁵; and
30

31 Whereas, Some organized medicine groups have already acknowledged the need to distribute
32 vaccines to EDs and have even created basic educational material on how to set up an ED-
33 based vaccination program⁶; therefore be it
34

35 RESOLVED, That our American Medical Association acknowledge that our nation's COVID-19
36 vaccine rollout is not yet optimized, and we have a duty to vaccinate as many people in an
37 effective manner (Directive to Take Action); and be it further

1 RESOLVED, That our AMA work with other relevant organizations and stakeholders to lobby
2 the current Administration for the distribution of COVID-19 vaccinations to our nation's
3 emergency departments and urgent care facilities (Directive to Take Action); and be it further
4
5 RESOLVED, That our AMA advocate for additional funding to be directed towards increasing
6 COVID-19 vaccine ambassador programs in emergency departments and urgent care facilities.
7 (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 06/06/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 rollout is happening as we speak, but if we are going to vaccinate enough people to return to a pre-COVID-19 state, we need to continue to vaccinate patients where they are. In addition to promoting vaccines in physician offices, we need to also be promoting the vaccines in the places patients who don't have a PCP visit such as urgent cares and emergency departments. This is time sensitive as the longer we wait to vaccinate the population, the more people will contract the virus.

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RELEVANT AMA POLICY

An Urgent Initiative to Support COVID-19 Vaccination Programs D-440.921

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.

Citation: Res. 408, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(JUN-21)

Introduced by: Medical Student Section

Subject: Classification and Surveillance of Maternal Mortality

Referred to: Reference Committee B

1 Whereas, The United States is the only developed country in the world that reported a projected
2 increase in maternal mortality rate from 2003-2013, despite global trends of accelerated
3 decline¹⁻³; and
4

5 Whereas, Since 2007, the U.S. has not published an official yearly maternal mortality rate in the
6 annual National Vital Statistics Report, which is the publication used to compare mortality rates
7 internationally^{4,5}; and
8

9 Whereas, A lack of standardized definitions and terminology between state and national health
10 organizations when attempting to quantify state-wide and national maternal mortality rates has
11 led to inconsistencies and inaccuracies when reporting these quantities⁶; and
12

13 Whereas, Due to the difficulty of interpreting the inconsistent data, the U.S. has stopped
14 publishing the official maternal mortality rate^{2,5}; and
15

16 Whereas, Without a reliable annual report of maternal mortality rate, an accurate assessment of
17 annual trends and international comparisons cannot be made^{2, 4-5}; and
18

19 Whereas, Although the Centers for Disease Control tracks maternal mortality data and
20 periodically makes it available to the public, the CDC is reliant on voluntary reporting and does
21 not generate an annual report of maternal mortality rate^{3,7}; and
22

23 Whereas, The CDC's surveillance reports on maternal mortality and morbidity do not distinguish
24 incarceration status^{8,9} despite the established relationship between incarceration and
25 increased risk of adverse birth outcomes and an increased need for pregnancy-related medical
26 care in prisons⁸⁻¹⁸; and
27

28 Whereas, Due to concerns about privacy, only researchers who have undergone Institutional
29 Review Board approvals are able to gain access to maternal mortality data⁷; and
30

31 Whereas, Despite significant efforts to reduce the maternal mortality rate in the U.S.--such as
32 Preventing Maternal Deaths Act of 2018, which provides the funding necessary to study
33 maternal morbidity and mortality data at the state levels--dissemination of data to the public has
34 been delayed^{2,6,19} ^{←8}; and
35

36 Whereas, State and federal Maternal Mortality Review Committees already use data from
37 surveillance of perinatal outcomes to improve understanding of disparities among racial groups
38 and inform the development of policies and initiatives aimed at meeting the needs of high-risk
39 populations, but data on incarceration status is not included in this surveillance²⁰ 7; and

1 Whereas, Limited data is available regarding health outcomes of incarcerated pregnant people
2 despite the high frequency of pre-existing health conditions in incarcerated populations, and the
3 established relationship between incarceration and exacerbation of pre-existing medical
4 conditions^{8,21-23}; and

5
6 Whereas, In 2010, Amnesty International issued a highly critical report on the state of maternal
7 mortality in the U.S., recommending that maternal mortality and morbidity trends be made
8 publicly available and states should be mandated to report such data to federal agencies
9 annually¹⁹; and

10
11 Whereas, The 2019 Maternal Mortality Summit report from the U.S. Department of Health and
12 Human Services Health Resources and Services Administration found the need to improve the
13 quality and availability of national data on maternal mortality⁶; and

14
15 Whereas, Unlike developing countries that face difficulties in tracking mortality rates overall, the
16 United States already has a reliable national vital statistics report system in place to enable
17 identification of maternal deaths, as long as states are able to utilize consistent reporting
18 standards²³; and

19
20 Whereas, Existing AMA policies D-420.993, D-245.994, and H-60.909 on maternal mortality rate
21 and maternal mortality surveillance promote state-level action and federal support for state
22 programs that monitor maternal mortality and morbidity, but falls short of specifying the need for
23 a reliable, standardized national maternal mortality report, limiting the impact of current AMA
24 policies for they fail to elucidate the national trends of maternal mortality and morbidity; and

25
26 Whereas, As maternal mortality is a key public health issue that concerns all healthcare
27 providers—not just those who research maternal mortality—the barriers to access information
28 regarding recent maternal mortality rates should be alleviated⁶; and

29
30 Whereas, Our AMA acknowledges the importance of access to healthcare for incarcerated
31 individuals, has supported standards to improve the safety of pregnant incarcerated people, and
32 advocates for protections for breastfeeding practices for incarcerated mothers; and

33
34 Whereas, Having annual maternal mortality rate reports can help healthcare providers and
35 society monitor the efforts to reduce maternal mortality and keep such programs
36 accountable^{7,19}; therefore be it

37
38 RESOLVED, That our American Medical Association advocate for an annual release of the
39 national maternal mortality rate in the United States (Directive to Take Action); and be it further

40
41 RESOLVED, That our AMA collaborate with relevant stakeholders to advocate for a reliable,
42 accurate, and standardized definition of maternal mortality that will be implemented across
43 states for tracking data on maternal mortality (Directive to Take Action); and be it further

44
45 RESOLVED, That our AMA encourage research efforts to characterize the health needs for
46 pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates
47 (Directive to Take Action); and be it further

48
49 RESOLVED, That our AMA support legislation requiring all correctional facilities, including those
50 that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics
51 with transparency in the data collection process. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 06/06/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be a priority at the June 2021 meeting given our AMA's commitment to health equity.

Reducing disparities in maternal mortality has been a longstanding priority of our AMA. However, **this resolution addresses a specific gap within existing AMA policy**, as confirmed by our conversations with AMA advocacy staff. **In particular, the idea of a standardized definition of maternal mortality and the associated national tracking of data was not something that has been effectively covered.** Different states monitor and report maternal mortality surveillance which then tends to lead to non-reliable data to create appropriate interventions.

It is critical to have access to the correct and most accurate maternal mortality rates so that the appropriate interventions could be created to help decrease this number across the country. There is trust that we know how to decrease the maternal mortality, but that can only be done if the data of maternal mortality reported is standardized and accurate across the US.

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RELEVANT AMA POLICY

Disparities in Maternal Mortality D-420.993

Our AMA: (1) will ask the Commission to End Health Care Disparities to evaluate the issue of health disparities in maternal mortality and offer recommendations to address existing disparities in the rates of maternal mortality in the United States; (2) will work with the CDC, HHS, state and county health departments to decrease maternal mortality rates in the US; (3) encourages and promotes to all state and county health departments to develop a maternal mortality surveillance system; and (4) will work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities.

(CSAPH Rep. 3, A-09Appended: Res. 403, A-11Appended: Res. 417, A-18)

Infant Mortality D-245.994

(1) Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers. (2) Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevalence of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparative effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.

(Res. 410, A-10; Reaffirmed: CSAPH Rep. 01, A-20)

State Maternal Mortality Review Committees H-60.909

Our AMA supports: (1) the important work of maternal mortality review committees; (2) work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and (3) work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

(Res. 911, I-17)

Infant Mortality Statistics H-245.998

The AMA (1) requests that all countries use a standard form of reporting births in their country and the deaths that result per 1,000 live births based on rules and regulations set up by the World Health Organization; and (2) supports publicizing that the medical profession is vitally

concerned with infant mortality rates and pledges to continue its efforts to decrease the infant mortality rates in the US to the lowest rate possible.

(Res. 7, I-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed by BOT Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17)

International Infant Mortality Data H-245.987

The AMA supports taking steps to make the public aware that baseline data differences exist in comparison studies, so that information presented for political purposes may be misleading.

(BOT Rep. HH, A-91; Reaffirmed by BOT Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07

Modified: CSAPH Rep. 01, A-17)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(JUN-21)

Introduced by: Medical Student Section

Subject: Considerations for Immunity Credentials During Pandemics and Epidemics

Referred to: Reference Committee B

1 Whereas, Policymakers are searching for novel ways to safely remove travel restrictions and
2 social distancing mandates amidst the severe acute respiratory syndrome coronavirus 2 (SARS-
3 CoV-2) and coronavirus infectious disease-19 (COVID-19) pandemic¹; and
4

5 Whereas, Immunity passports are currently defined by legal experts as digital or physical
6 documents that certify an individual has been infected and is purportedly immune to SARS-
7 CoV-2 and individuals in possession of such documents could be exempt from physical
8 restrictions¹; and
9

10 Whereas, Effective long-term immunity conferred by SARS-CoV-2 exposure, either by
11 vaccination or infection, is not known^{2,3}; and
12

13 Whereas, Immunity passports do not account for the possibility of SARS-CoV-2 reinfection even
14 by those who have tested positive by the serological antibody test as we do yet not know what
15 level of antibody titer is required for immunity^{4,5}; and
16

17 Whereas, The United States and several other countries have proposed an immunity passport
18 that certifies prior infection and immunity against SARS-CoV-2, which is misleading due to the
19 difficulty in certifying immunity for a novel virus¹; and
20

21 Whereas, Immunity passports would negatively impact vulnerable populations by decreasing
22 liberty because of restricting mobility and opportunity for individual development (e.g.
23 professional growth, leisure, relationships)^{6,7}; and
24

25 Whereas, Immunity passports would increase health disparities and stigmatization by promoting
26 infections among those who cannot access affordable vaccines^{6,7}; and
27

28 Whereas, Immunity passports would exacerbate social inequality by inequitable distribution of
29 passports based on access to care and access to testing, and rationing of passports based on
30 class⁸; and
31

32 Whereas, Immunity passports would introduce a new risk for discrimination if employers,
33 insurance companies, law enforcement, and other powerful entities could access private health
34 information for their own benefit⁸; and
35

36 Whereas, Immunity passports would pose considerable risk of corruption by privileging queues
37 for infection certification and burdensome application processes, and risk of bias by creating
38 restrictions on who can take part in social, civic, and economic activities⁹; and

1 Whereas, Immunity passports would incentivize individuals to seek out infection so that they
2 may be relieved of restrictions, especially people who are unable to afford a period of workforce
3 exclusion, compounding existing gender, race, ethnicity, and nationality inequities^{9,10}; and
4

5 Whereas, The World Health Organization (WHO), European Centre for Prevention and Control
6 (ECDC), International Air Transport Association (IATA), and International Civil Aviation
7 Organization (ICAO) advocate against immunity passport implementation under present
8 circumstances and test performance¹¹; therefore be it
9

10 RESOLVED, That our American Medical Association oppose the implementation of natural
11 immunity credentials, which give an individual differential privilege on the basis of natural
12 immunity after non-vaccine exposure status to a pathogen (Directive to Take Action); and be it
13 further
14

15 RESOLVED, That our AMA caution that any implementation of vaccine-induced immunity
16 credentials, which give an individual differential privilege on the basis of acquired immunity after
17 receiving a vaccine, must strongly consider potential consequences on social inequity,
18 including, but not limited to: (i) continued marginalization of communities historically harmed or
19 ignored by the healthcare system; (ii) isolation of populations who may be ineligible for or
20 unable to access vaccines; (iii) barriers preventing immigration or travel from countries with low
21 access to vaccines and the need to offer a vaccine upon arrival to anyone entering the US from
22 another country; and (iv) privacy of and accessibility to any systems used to implement vaccine-
23 induced immunity passports. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 06/06/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be a priority at the J21 given that addresses a similar topic as BOT Report 18.

Health equity has been at the forefront of the AMA's advocacy efforts, especially in the context of the COVID-19 pandemic. This resolution asks our AMA to recognize the potential for immunity passports (also known as immunity credentials, certification, verification, among others) to have a large risk of exacerbating inequalities and allowing only a certain elite with good medical care and access to antibody testing to be eligible for travel and economic opportunities. The World Health Organization has already published commentary and opposition to immunity passports, and **given current national conversations on this issue and the implementation of these passports in various cities including Chicago, we believe this resolution warrants full consideration by our House of Delegates.** The AMA has both an opportunity and responsibility to raise its voice in defense of our patients and public health and will help to prepare us for any future public health emergencies.

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RELEVANT AMA POLICY**Ethical Use of Quarantine and Isolation Code of Ethics 8.4**

The medical profession, in collaboration with public health colleagues and civil authorities, has an ethical responsibility to: (h) Ensure that quarantine measures are ethically and scientifically sound: § Use the least restrictive means available to control disease in the community while protecting individual rights; § Without bias against any class or category of patients. (i) Advocate for the highest possible level of confidentiality when personal health information is transmitted in the context of public health reporting. (j) Advocate for access to public health services to ensure timely detection of risks and implementation of public health interventions, including quarantine and isolation. (k) Advocate for protective and preventive measures for physicians and others caring for patients with communicable disease. (l) Develop educational materials and programs about quarantine and isolation as public health interventions for patients and the public.

AMA Principles of Medical Ethics: I, III, VI, VII, VIII

Issued: 2016

Support for Public Health D-440.997

Our AMA House of Delegates request the Board of Trustees to include in their long range plans, goals, and strategic objectives to support the future of public health in order "to fulfill society's interest in assuring the conditions in which people can be healthy." This shall be accomplished by AMA representation of the needs of its members, patients in public health-related areas, the promotion of the necessary funding and promulgation of appropriate legislation which will bring this to pass. Our AMA: (A) will work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease; (B) recognizes a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state public health functions and resources; and (C) in concert with state and local medical societies, will continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes. Our AMA recognizes the importance of timely research and open discourse in combating public health crises and opposes efforts to restrict funding or suppress the findings of biomedical and public health research for political purposes.

Res. 409, A-99; Modified: CLRPD Rep. 1, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Appended: Res. 206, A-13; Reaffirmation: A-15; Appended: Res. 902, I-16

Nonmedical Exemptions from Immunizations H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA i. Supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; ii. Supports legislation eliminating nonmedical exemptions from immunization; iii. Encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; iv. Encourages physicians to grant vaccine exemption requests only when medical contraindications are present; v. Encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and vi. Recommends that states have in place: i. An established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and ii. Policies that permit immunization exemptions for medical reasons only.

2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to eliminate non-medical exemptions from mandated pediatric immunizations.

CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed; CSAPH Rep. 3, A-07; Reaffirmed: Res. 10, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 416, A-19

AMA Role in Addressing Epidemics and Pandemics H-440.835

Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.

Sub. Res. 925, I-14; Reaffirmed: Res. 418, A-17

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(JUN-21)

Introduced by: Medical Student Section

Subject: Increasing Access to Menstrual Hygiene Products

Referred to: Reference Committee B

1 Whereas, Feminine hygiene products, also known as menstrual care products, are classified as
2 tampons, pads, liners, cups, sponges, or similar products used by individuals with respect to
3 menstruation or other genital-tract secretions^{1,2}; and
4

5 Whereas, Organizations including the United Nations and Human Rights Watch have classified
6 menstrual hygiene as a human rights issue³; and
7

8 Whereas, In 2018, the estimated life-time cost of menstrual products for an individual in the
9 United States was \$1,773.33⁴; and
10

11 Whereas, Two-thirds of low-income women in the United States of America were unable to
12 afford menstrual products in 2018⁵; and
13

14 Whereas, OSHA requires employers to provide all workers with sanitary and immediately-
15 available toilet facilities (restrooms) according to sanitation standards 29 CFR 1910.141, 29
16 CFR 1926.51 and 29 CFR 1928.110⁶; and
17

18 Whereas, There are 166,650,550 women in the United States, of which 75 million are of
19 childbearing age⁷, requiring the use of 7 billion tampons and 12 billion pads last year in 2019⁸;
20 and
21

22 Whereas, The use of make-shift menstrual sanitation products and neglected menstrual hygiene
23 increases the risk of negative health effects including toxic shock syndrome, reproductive tract
24 infections (RTI), and other vaginal diseases^{9,10}; and
25

26 Whereas, School-aged children in the United States who are unprepared for menarche have
27 increased rates associated with depression, substance abuse, delinquency, and school
28 dropout¹¹; and
29

30 Whereas, The 2017 Always Confidence & Puberty Survey showed that one in five school-aged
31 girls in the United States have left school early or missed an entire day of school due to lack of
32 access to menstrual products¹²; and
33

34 Whereas, An estimated 86% of women have started their period in public without ready access
35 to these necessary medical devices and 72% of these women left work early to obtain
36 supplies¹³; and
37

38 Whereas, Currently five states (i.e., California, Georgia, Illinois, New York, and New Hampshire)
39 have implemented legislation to provide free menstrual products (i.e., tampons, sanitary
40 napkins) in public school restrooms¹⁴⁻¹⁸; and

Whereas, Multiple pieces of legislation have highlighted the movement towards menstrual equity for all by calling for free and accessible menstrual products in public schools, establishing menstrual hygiene products as medical necessities, and allowing purchases for menstrual care products to be eligible for reimbursement through Health Flexible Spending Arrangements and Health Reimbursement Arrangements^{19,20}; and

Whereas, The AMA considers menstruation a normal bodily function and considers menstrual products to be necessities for women per AMA policy H-525.974; and

Whereas, AMA policy H-170.996 reaffirms local societies establishing relationships with schools to aid in health education, particularly in personal hygiene; therefore be it

RESOLVED, That our American Medical Association recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA support the distribution of menstrual products and inclusion of menstrual product disposal systems in educational institutions (Directive to Take Action); and but it further

RESOLVED, That our AMA encourage public and private institutions as well as places of work to provide free, readily available menstrual care products to workers and patrons (Directive to Take Action); and be it further

RESOLVED, That our AMA amend policy H-525.974, "Considering Feminine Hygiene Products as Medical Necessities", by addition to read as follows:

Considering Feminine Hygiene Products as Medical Necessities, H-525.974

Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; ~~and~~ (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs; and (3) encourage the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA support the inclusion of medically necessary hygiene products, including, but not limited to, menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for federal legislation that increases the access to menstrual hygiene products, especially for recipients of public assistance (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA work with state medical societies to advocate for state legislation
2 that increases access to menstrual hygiene products, especially for recipients of public
3 assistance. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 06/06/21

AUTHOR'S STATEMENT OF PRIORITY

We feel very strongly that this resolution should be considered as a priority for the June 2021 Meeting. Access to menstrual hygiene products has been labeled by the UN as a public health crisis. This lack of access to menstrual hygiene products (also known as period poverty) has both serious physical and emotional health implications particularly for communities who have and continue to be marginalized and minoritized. Period Poverty in the United States has significantly worsened as a result of the public health emergency. This issue affects everyone, not just people who menstruate. Two in five people report extreme difficulty purchasing period products, and one in four Black and Latinx individuals report struggling to afford these critical menstrual hygiene products. **As we continue to turn towards a lens of equity, championing this issue is a great way for the AMA to utilize our resources.** Legislators are pushing for increased access to menstrual hygiene products on both State and Federal levels. Unfortunately, the policy that we currently have surrounding menstrual hygiene products has not been strong enough to allow the AMA to push further on this advocacy opportunity. Our proposed change policy would allow us to firmly stand in support and advocate for such efforts. The formal actions of our AMA in effort to end Period Poverty may be the push needed to end this public health crisis.

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RELEVANT AMA POLICY

Considering Feminine Hygiene Products as Medical Necessities H-525.974

Our AMA will: (1) Encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; (2) Work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products, including tampons for their needs. (Res. 218, A-18)

Tax Exemptions for Feminine Hygiene Products H-270.953

Our AMA supports legislation to remove all sales tax on feminine hygiene products. (Res. 215, A-16)

Establishing Active Liaison with Schools and Colleges H-170.996

Our AMA encourages state and local societies to establish liaison relationships with schools to provide appropriate assistance in health education, particularly personal hygiene, substance misuse, smoking, sexually transmitted disease, quackery, and the role of the physician in maintaining good health. (Res. 72, A-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-20)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(JUN-21)

Introduced by: Private Practice Physicians Section

Subject: Preventing Inappropriate Use of Patient Protected Medical Information in the
Vaccination Process

Referred to: Reference Committee B

1 Whereas, Retail pharmacies have played a key role in expanding access to COVID-19
2 vaccination; and

3
4 Whereas, Many larger retail pharmacies are collecting a significant amount of medical history
5 and contact information from patients seeking to schedule COVID-19 vaccinations, sometimes
6 even for those merely seeking to see if an appointment is available; and

7
8 Whereas, Some larger retail pharmacy chains see this as an opportunity to recruit patients to
9 utilize their retail health clinics for routine visits in competition with a patient's medical home;
10 and

11
12 Whereas, These chains are indicating to investors that they plan to utilize this information to
13 "expand our customer base while deepening relationships with current customers" and to make
14 "measurable and important progress with our strategy as a health services company" including
15 using such information for future marketing to these patients or recruiting patients to their
16 associated retail health clinics and integrated health platforms; and

17
18 Whereas, Some scheduling assistant websites or private providers asked about various medical
19 conditions to assess eligibility priority and may have retained the information; and

20
21 Whereas, A coalition of digital privacy advocates have raised concerns that HIPAA may not
22 necessarily cover data that is given for vaccination scheduling; and

23
24 Whereas, Privacy concerns may deter patients from obtaining vaccines; therefore be it

25
26 RESOLVED, That our American Medical Association advocate to prohibit the use of
27 patient/customer information collected by retail pharmacies for COVID-19 vaccination
28 scheduling and/or the vaccine administration process for commercial marketing or future patient
29 recruiting purposes, especially any targeting based on medical history or conditions (Directive to
30 Take Action); and be it further

31
32 RESOLVED, That our AMA oppose the sale of medical history data and contact information
33 accumulated through the scheduling or provision of government-funded vaccinations to third
34 parties for use in marketing or advertising. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 06/06/21

AUTHOR'S STATEMENT OF PRIORITY

Many states have preferenced pharmacies over physician offices for vaccine distribution during this pandemic. Patients were often forced to search for appointments using corporate websites for CVS, Walgreens, etc., which often requested account registration, contact information, and even medical histories before allowing access to the vaccine availability pages. This has allowed these pharmacies to gain valuable patient data, even of patients who never received a vaccine from them. Retail pharmacies have stated they intend to use this information to market their other health services including urgent care and primary care alternatives, in direct competition with patients' doctors. In addition, they may use this data to target their marketing and advertising based on the medical conditions that they have collected. The AMA should advocate to prohibit this use of data for these unintended and non-patient care related purposes.

This resolution is timely as this data continues to be collected and physicians still have limited access to vaccines, making retail pharmacies one of the primary sources of vaccines. AMA can have a significant impact in calling attention to this issue and advocate for legislation or regulation that could be tied to continuing vaccine distributions to enact these key patient protections. This situation affects millions of Americans who either received their vaccine through a pharmacy or registered with one of the pharmacies in order to search for an appointment. There is a need to act now while COVID-19 vaccination is still ongoing to ensure this data is properly protected.

RELEVANT AMA POLICY

Ethical Opinion 3.1.1 Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.

Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

- a. Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.
- b. Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
- c. Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

Police, Payer, and Government Access to Patient Health Information H-315.975

(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

Citation: Res. 246, A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: BOT Rep. 22, A-17

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:

(a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on

signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified

whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Citation: BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(JUN-21)

Introduced by: Medical Student Section

Subject: Medical Honor Society Inequities and Reform

Referred to: Reference Committee C

1 Whereas, Induction into the medical honor societies Alpha Omega Alpha (AOA) and Gold
2 Humanism Honor Society (GHHS) is associated with numerous benefits including increasing
3 students' odds of receiving residency interview offers, matching into their preferred specialty,
4 and becoming academic faculty^{1,2}; and

5
6 Whereas, Honor society status does not correlate with residency performance³; and

7
8 Whereas, Although there are basic guidelines and restrictions on honor society student
9 selection, selection of student inductees into honor societies is determined individually by each
10 institution^{4,5}; and

11
12 Whereas, Recent scrutiny has exposed racist, sexist, classist, and other discriminatory
13 implications of the selection criteria for AOA and GHHS ⁶⁻¹⁰; and

14
15 Whereas, Underrepresented minority students and students from disadvantaged backgrounds
16 are significantly less likely to receive honors grades and subsequently even less likely to be
17 induced into AOA despite similar standardized test scores and clerkship evaluations ^{9,11}; and

18
19 Whereas, While although allowing individual institutions to develop their own selection criteria
20 can result in important adaptations made for an institutions' unique curriculums and student
21 demographics, this can also lead to continuing inequities in the allocation of opportunities to
22 various student demographic groups where differing criteria can make comparing students
23 across institutions difficult ^{7,11,12}; and

24
25 Whereas, Some distinguished medical schools including the University of California, San
26 Francisco School of Medicine and Ichan School of Medicine at Mount Sinai have already
27 removed affiliations with honors societies such as AOA due to inequity^{13,14}; and

28
29 Whereas, Reform or abolition of medical honor societies could mitigate some inequities leading
30 to cascades of consequences for underrepresented students ¹¹; therefore be it

31
32 RESOLVED, That our American Medical Association recognize that demographic and
33 socioeconomic inequities exist in medical student membership in medical honor societies (New
34 HOD Policy); and be it further

35
36 RESOLVED, That our AMA study reforms to mitigate demographic and socioeconomic
37 inequities in the selection of medical students for medical honor societies, including Alpha
38 Omega Alpha and the Gold Humanism Honor Society, as well as the implications of ending the
39 selection of medical students to these societies on equity in the residency application process
40 and report back to the November 2021 HOD meeting. (Directive to Take Action)

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

Received: 06/06/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be considered at the J21 Meeting due to final recommendations by the Coalition of Physician Accountability, of which our AMA is an active stakeholder.

Induction into medical honor societies, including Alpha Omega Alpha (AOA) and Gold Humanism Honor Society (GHHS), is associated with numerous benefits: residency interview offers, preferred specialty match rates, and academic faculty employment. However, criteria are highly variable across institutions and recent scrutiny has exposed racist, sexist, classist, and other discriminatory implications where underrepresented minority students and students from disadvantaged backgrounds are significantly less likely to be inducted despite similar standardized test scores and clerkship evaluations. These inequities have cascading downstream negative effects, causing many bodies to call for reform including the Coalition for Physician Accountability, of which our AMA is an active stakeholder, which recommended in their late April report that "exploring" bias in honor society selection, specifically listing AOA and GHHS, should be a priority for medical schools. The gauntlet now falls to its constituent organizations to implement these recommendations. While many schools in the last year have sought to reform or end selection to these societies, consensus from national bodies on the best way to reform does not exist. The vast majority of medical schools either considering changes or responding to national pressure this upcoming academic year will look to our AMA and our partners for guidance.

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RELEVANT AMA POLICY

Underrepresented Student Access to US Medical Schools H-350.960

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the

diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15

Continued Support for Diversity in Medical Education D-295.963

1. Our American Medical Association will publicly state and reaffirm its stance on diversity in medical education.

2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups.

Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13

Progress in Medical Education: the Medical School Admission Process H-295.888

1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.

2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.

CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.

4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater

understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Res. 5, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: The Impact of Private Equity on Medical Training

Referred to: Reference Committee C

1 Whereas, The corporate practice of medicine doctrine is an ever-developing set of laws and
2 rules prohibiting lay corporations from practicing medicine or employing a physician to provide
3 professional medical services¹; and
4

5 Whereas, State corporate practice of medicine laws have numerous loopholes, including
6 exceptions for professional corporations and for physicians employed by certain healthcare
7 entities, including, but not limited to, hospitals¹; and
8

9 Whereas, Some, but not all, states have explicit laws protecting employed physician autonomy
10 in clinical decision-making and even among these states there is variability¹; and
11

12 Whereas, Retention of physician autonomy in medical practice has been used by private equity
13 firms and other corporate entities in state-level licensure rulings to determine that physician
14 employment does not constitute the corporate practice of medicine or violate such laws¹; and
15

16 Whereas, Private equity firms are defined as financial organizations that acquire equity in
17 businesses with funds provided by private investors²; and
18

19 Whereas, There remains little peer-reviewed evidence of the impact of corporate investors and
20 private equity on physicians, patients, and health care prices²; and
21

22 Whereas, There has been in increasing number of medical practices with majority ownership
23 from private equity firms, but the degree of investment cannot be precisely determined due to
24 the common use of nondisclosure agreements²; and
25

26 Whereas, A recent cohort study comparing 204 hospitals acquired by private equity firms from
27 2005 to 2017 and 532 matched hospitals not acquired by private equity firms demonstrated that
28 acquired hospitals had subsequent increases in total charges per inpatient days and total
29 charges compared to costs, and a decrease in Medicaid and Medicare discharges, but
30 demonstrated improvement in some quality measures³; and
31

32 Whereas, In 2019, the Hahnemann Medical Center, a safety net hospital in Philadelphia,
33 declared bankruptcy and a consortium of hospitals submitted a winning bid of \$55 million for
34 550 government-funded residency slots⁴, thus demonstrating a naked attempt at private equity
35 seeking to control Graduate Medical Education (GME) training positions; and
36

37 Whereas, Section 5506 of the Affordable Care Act addressed the issue of “lost” resident cap
38 positions due to teaching hospital closure by instructing the U.S. Secretary of Health and
39 Human Services to establish a process by regulation that would redistribute slots from teaching

1 hospitals that close to hospitals that meet certain criteria⁵, though there is limited public data to
2 show where these positions are redistributed to; and
3

4 Whereas, Geographic inequity in where direct and indirect GME monies flow, relative to where
5 they are needed⁴, may contribute to hospital systems seeking alternative sources of funding to
6 expand GME positions; and
7

8 Whereas, The AMA has only peripherally addressed protections for physicians in training
9 related to the corporate practice of medicine, recommending, "that physicians in training should
10 not be asked to sign covenants not to compete as a condition of entry into any residency or
11 fellowship program"⁶; and
12

13 Whereas, GME training positions created by private equity funding have been increasing in
14 recent years in multiple specialties, most notably emergency medicine, but there is little
15 published on the subject; and
16

17 Whereas, Medical trainees do not have the same ability as practicing physicians to negotiate or
18 protect themselves from the potential involvement or influence of corporate investors or private
19 equity in their education; and
20

21 Whereas, The creation of additional GME positions in specialties without consideration of post-
22 training positions may lead to further imbalanced⁷ physician market inefficiencies wherein too
23 many physicians are trained in some specialties, while other specialties see continued or
24 worsened existing physician shortages; therefore be it
25

26 RESOLVED, That our American Medical Association work with relevant stakeholders including
27 specialty societies and the Accreditation Council for Graduate Medical Education to study the
28 level of financial involvement and influence private equity firms have in graduate medical
29 education training programs and report back at the 2021 Interim Meeting with concurrent
30 publication of their findings in a peer-reviewed journal. (Directive to Take Action)

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

Received: 06/06/21

AUTHORS STATEMENT OF PRIORITY

As we have seen in the ACEP workforce report, private equity has been impacting the number of training programs in emergency medicine, internal medicine, and family medicine at an alarming pace. While GME expansion is needed, we need to ensure that we are training physicians for the needs of our patients, not businesses. In addition to ensuring that we are promoting residencies where they are needed, we need to ensure quality of training to keep the public trust in the value of physician education and residencies. Given its rapid proliferation and recent plan by the ACGME to develop guidelines, we need the AMA provide guidance on the impact private equity is having on medical education and formulate next steps needed before patient care and trust in our profession is irreparably harmed.

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RELEVANT AMA POLICY

Corporate Investors H-160.891

1. Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
 - a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
 - b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
 - c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
 - d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
 - e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
 - f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
 - g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
 - h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
 - i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
 2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
 3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
 4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.
- Citation: CMS Rep. 11, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 319
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: The Effect of the COVID-19 Pandemic on Graduate Medical Education

Referred to: Reference Committee C

1 Whereas, The COVID-19 pandemic has disrupted global healthcare in an unprecedented
2 manner for modern times and inherent in this disruption has been the effect on medical trainees
3 worldwide; and
4

5 Whereas, Resident and fellow physicians have experienced lower clinical volume, cancellation
6 of didactic learning opportunities and career networking, redeployment to unfamiliar clinical
7 environments and impacts on their progress towards board certification; and
8

9 Whereas, Residents and fellows in both surgical and non-surgical specialties were frequently
10 not afforded resources such as adequate personal protective equipment, mental health support
11 or adequate compensation for their extra work-related duties, and emotional and physical
12 stress; and
13

14 Whereas, The COVID-19 pandemic has significantly impacted various components of training
15 including surgical case exposure and opportunities to care for various patient populations in a
16 variety of settings; and
17

18 Whereas, While long-term impacts on quality of care provided by these affected GME trainees
19 is yet to be seen, careful monitoring going forward is essential; and
20

21 Whereas, It may be determined that more focus on objective competency measurements may in
22 turn provide a better guide of resident and/or fellow training than case or clinical volume with the
23 potential to create more robust training programs with shorter durations; therefore be it
24

25 RESOLVED, That our American Medical Association work with the Accreditation Council for
26 Graduate Medical Education (ACGME) and other relevant stakeholders to provide additional
27 benefits for compensation, such as moonlighting, hazard pay, and/or additional certifications for
28 residents and fellows who are redeployed to fulfill service needs that are outside the scope of
29 their specialty training (Directive to Take Action); and be it further
30

31 RESOLVED, That our AMA urge ACGME to work with relevant stakeholders including residency
32 and fellowship programs to ensure each graduating resident or fellow is provided with
33 documentation explicitly stating his/her board eligibility and identifying areas of training that
34 have been impacted by COVID-19 that can be presented to the respective board certifying
35 committee (Directive to Take Action); and be it further
36

37 RESOLVED, That our AMA urge ACGME and specialty boards to consider replacing minimums
38 on case numbers and clinic visits with more holistic measures to indicate readiness for
39 graduation and board certification eligibility, especially given the drastic educational barriers
40 confronted during the COVID-19 pandemic. (Directive to Take Action)

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

Received: 06/06/21

AUTHORS STATEMENT OF PRIORITY

Trainees graduating not only this year but over the next several years will be impacted by the reduced patient visits and reduced surgical cases they had the opportunity to have exposure to. This may impact graduation requirements and board eligibility. While many areas of GME have been innovating on competency based education, COVID-19 has accelerated the need to address how all residencies will address this for the coming years of graduates impacted by COVID-19 and the AMA needs to act quickly if we are to help protect not only these residents' careers but to ensure patient trust in their training.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(JUN-21)

Introduced by: Texas

Subject: Impact of Social Networking Services on the Health of Adolescents

Referred to: Reference Committee D

1 Whereas, Distinct from use of the broader internet, the use of social networking services (SNS)
2 such as Facebook, Twitter, Instagram, Tik Tok, and Snapchat, among others, which are
3 engineered to maximize engagement and have potential for addiction, can result in a
4 dependence with a severity of symptoms and consequences traditionally associated with
5 substance-related addictions; and
6

7 Whereas, Adolescents are particularly vulnerable to unhealthy SNS use, the negative effects of
8 which are incompletely understood but involve psychosocial health, neurocognitive
9 development, weight, and sleep; exposure to inaccurate, inappropriate, or unsafe content and
10 contacts; and compromised privacy and confidentiality; and
11

12 Whereas, Adolescents under the age of 18 are not recognized in the law as adults, nor do they
13 have the fully developed capacity of adults to understand the risks and long-term implications of
14 online communication, yet they regularly enter into contractual agreements with operators of
15 websites to send and post information about themselves without the knowledge or consent of
16 their parents; and
17

18 Whereas, Many of the protections under the Children's Online Privacy Protection Act of 1998
19 such as verifiable parental consent may be beneficial if extended to adolescents, yet they
20 currently apply only to children under age 13; therefore be it
21

22 RESOLVED, That our American Medical Association affirm that use of social networking
23 services has the potential to negatively impact the physical and mental health of individuals,
24 especially adolescents and those with preexisting psychosocial conditions, and therefore these
25 services should have established, evidence-based, reliable safeguards to protect vulnerable
26 populations from harm (New HOD Policy); and be it further
27

28 RESOLVED, That our AMA advocate for the study of the biological, psychological, and social
29 effects of social networking services use, and advocate for legislative or regulatory action,
30 including the expansion of Children's Online Privacy Protection Act of 1998 protections, to
31 mitigate the potential harm from the use of social networking services to adolescents and other
32 vulnerable populations. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 05/20/21

AUTHOR'S STATEMENT OF PRIORITY

Social networking services “SNS” (i.e. Facebook, Twitter, Instagram, Snapchat, etc.) leverage powerful machine-learning algorithms and immense data collection for profit. The product which SNS platform sells is nothing less than the gradual change of an individual’s thoughts, feelings, attitudes and behaviors. Far from benign, this process deploys sophisticated techniques that exploit human psychology to increase dependence upon the platform, possibly to the point of addiction. Use of SNS has been associated with detrimental effects to one’s mental health, coping ability, feelings of self-worth and satisfaction as well as measurable alterations in cerebral structures. The effects of SNS use have not been rigorously studied, especially the impact on the developing brain, psychological health and at-risk populations.

In response, the regulatory environment has failed to keep up with the now ubiquitous nature of SNS. The few protections that exist (Children’s Online Privacy and Protection Act) don’t apply for children older than 12 years of age. Our children are placed at a great disadvantage against an ever-improving algorithm that values engagement and manipulation over individual well-being.

This resolution should be acted upon immediately to take advantage of growing awareness of the issues as depicted in the popular documentary “The Social Dilemma”. There is currently no AMA policy that addresses the unique nature of SNS use and the detrimental impact it can have on the health of adolescents and children. There is growing bipartisan support for increased regulation in this space and our AMA should support greater regulatory and legislative protections for our children.

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RELEVANT AMA POLICY

Emotional and Behavioral Effects of Video Game and Internet Overuse H-60.915

Our AMA supports increased awareness of the need for parents to monitor and restrict use of video games and the Internet and encourage increased vigilance in monitoring the content of games purchased and played for children 17 years old and younger.

Citation: CSAPH Rep. 01, A-17; Reaffirmation: A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(JUN-21)

Introduced by: Medical Student Section

Subject: Medical Misinformation in the Age of Social Media

Referred to: Reference Committee D

1 Whereas, Misinformation is defined as any false information that is spread, regardless of
2 whether there was an intent to mislead¹; and
3

4 Whereas, Disinformation is defined as information that is deliberately misleading or false with
5 the intent to manipulate or harm a person or social group¹; and
6

7 Whereas, An example of medical misinformation includes the ‘anti-vaxx’ movement which has
8 legitimized concerns about vaccine safety and has been contributing to reductions in
9 vaccination rates and increases in vaccine-preventable diseases²; and
10

11 Whereas, Another example of misinformation is the ongoing debunked link between the MMR
12 vaccine and autism³; and
13

14 Whereas, Several studies have shown that more than half of health articles posted online
15 (including magazines, opinions, news pieces) having a quality which is deemed ‘problematic’³;
16 and
17

18 Whereas, COVID-19 is the first public health emergency in history in which technology and
19 social media are being used on a massive scale to keep people safe, informed, productive and
20 connected.⁴; and
21

22 Whereas, More than two-thirds of Americans receive their news from at least one social media
23 outlet which provides faster access than has been previously made possible⁵; and
24

25 Whereas, Information from social media outlets do not go through the same vetting processes
26 as credible news sources, allowing false information to be conveyed as real news⁶; and
27

28 Whereas, One analysis of videos posted to YouTube concerning COVID-19 found that 25% of
29 topic videos contained misleading information, totaling 62 million views worldwide⁷; and
30

31 Whereas, One study which analyzed 16,000 Twitter accounts sharing information around the
32 2016 presidential election found that only 0.1% of individuals shared more than 80% of the
33 misinformation content, highlighting a group commonly referred to as “super-spreaders”⁸; and
34

35 Whereas, The spread of misinformation may also be linked to a single individual having access
36 to multiple social networks, creating web links where users in one group link to a page on
37 various other platforms making it more difficult for programs developed by a single platform to
38 be implemented on a larger scale⁹; therefore be it

1 Whereas, The World Health Organization (WHO) termed the way misinformation spreads online
2 as an “infodemic” to represent how it can spread in an exponential manner³; and
3

4 Whereas, Numerous studies have shown that individuals most likely to engage with fake news
5 surrounding COVID-19 were conservative-leaning, highly engaged with political news, older
6 adults with a low level of trust in science, journalism, mainstream media, and government all
7 drivers for believing misinformation^{2,6,10,11}; and
8

9 Whereas, According to a Gallup poll conducted in 2016, only 26% of individuals in the US have
10 adequate confidence in the medical system and around 1 in 5 individuals express skepticism
11 about scientists themselves¹²; and
12

13 Whereas, Those who are more susceptible to COVID-19 misinformation have a lower level of
14 self-reported compliance with public health guidance, including vaccination, mask-wearing, and
15 social distancing putting themselves and countless other at risk of sickness and even death^{2,13};
16 and
17

18 Whereas, Recent evidence has shown that exposing online users to factual elaboration, even
19 as compared to simple rebuttal, can lead to open discussion and sharing of viewpoints and even
20 stimulate intentions to protective actions against COVID-19¹¹; and
21

22 Whereas, The AMA Code of Ethics calls on doctors to “make relevant information available to
23 patients, colleagues, and the public [and] recognize a responsibility to participate in activities
24 contributing to the improvement of the community and the betterment of public health” as it is
25 the physician’s duty to make scientifically accurate information available for the betterment of
26 society¹⁴; and
27

28 Whereas, The WHO calls on members to develop and implement action plans and promote
29 timely dissemination of accurate information based on science and evidence¹⁵; and
30

31 Whereas, Journalists have access to locally or nationally distributed news networks and
32 collaboration with physicians may provide potential audiences magnitudes greater than on
33 social media alone¹⁶; and
34

35 Whereas, The FDA has issued warning letters to several companies advertising false or
36 misleading drug or product claims regarding the treatment of COVID-19 and additionally has
37 regulatory authority to seize these products or pursue criminal penalties¹⁷; and
38

39 Whereas, Congress has passed additional legislation creating civil penalties for false or
40 misleading claims of products that treat, prevent or cure COVID-19¹⁷; and
41

42 Whereas, Medical misinformation can be policed at the platform-level through the protections
43 given by the Communications Decency Act §230 (§230), as social media companies can restrict
44 or censor any objectionable material, regardless of whether it is constitutionally-protected
45 speech¹⁸; and
46

47 Whereas, §230 also absolves these companies from liability regarding any individual users’
48 speech on a platform, removing liability incentives to moderate speech and medical
misinformation on a platform¹⁸; and

Whereas, Exceptions have since been carved out in §230, for example the 2018 FOSTA-SESTA legislation which eliminates §230 protections for content related to sex trafficking crimes¹⁹; therefore be it

RESOLVED, That our American Medical Association encourage social media organizations to further strengthen their content moderation policies related to medical misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage social media organizations to recognize the spread of medical misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to support the dissemination of accurate medical information by public health organizations and health policy experts (Directive to Take Action); and be it further

RESOLVED, That our AMA work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical information (Directive to Take Action); and be it further

RESOLVED, That our AMA amend existing policy D-440.921 concerning COVID-19 vaccine information to increase its scope and impact regarding medical misinformation by addition to read as follows:

An Urgent Initiative to Support COVID-19 Vaccination Information Programs D-440.921

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online. (Modify Current HOD Policy); and be it further

1 RESOLVED, That our AMA study and consider public advocacy of modifications to Section
2 230(c) of the Communications Decency Act, Part 2, Clause A, as follows:

3
4 any action voluntarily taken in good faith to restrict access to or availability of material
5 that the provider or user considers to be obscene, lewd, lascivious, excessively
6 violent, harassing, pose risk to public health, or be otherwise objectionable, whether
7 or not such material is constitutionally protected. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 06/06/21

AUTHOR'S STATEMENT OF PRIORITY

This item should be a priority at the J21 Meeting due to the negative impact that rampant medical misinformation has on public health.

The COVID-19 pandemic has demonstrated the dangers of medical misinformation, which contributed to over 500,000 lives lost. Although inaccurate medical information online is by no means a new phenomenon, an unprecedented number of people now rely on social media as their primary source of news. Emerging evidence suggests that **misinformation surrounding the COVID-19 public health emergency not only disincentivizes people from following public health guidelines, but also makes our jobs as practicing physicians more challenging** and has directly led to the death of many of our patients both in the United States and abroad. Despite the rising number of deaths from the pandemic, untrue and intentionally misleading news continues to spread, now surrounding the efficacy of vaccines and reported side effects, further complicating the public health effort.

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RELEVANT AMA POLICY

Anonymous Cyberspace Evaluations of Physicians D-478.980

Our AMA will: (1) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2) continue pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys.

Citation: (BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 717, A-12; Reaffirmation A-14)

Hospital Advertising in Printed and Broadcast Media H-225.994

In order to prevent medical misinformation, the AMA encourages: (1) medical staff participation in hospital administration decisions regarding marketing and advertising; and (2) hospital and medical advertising be consistent with federal regulatory standards and with the Code of Medical Ethics.

Citation: Res. 118, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05; Reaffirmed: CMS Rep. 1, A-15; Modified: Res. 215, A-18

An Urgent Initiative to Support COVID-19 Vaccination Programs D-440.921

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.

Citation: Res. 408, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(JUN-21)

Introduced by: Texas

Subject: Support for the Texas-CARES Program

Referred to: Reference Committee F

Whereas, Out-of-hospital cardiac arrest (OHCA), including or stemming from sudden cardiac death, drowning, and drug overdose, is a leading cause of death and a major public health problem with enormous impact; and

Whereas, Large and unacceptable geographic, racial, and socioeconomic disparities in access to basic life-saving care and OHCA survival rates exist; and

Whereas, A coordinated cardiac response system, including prompt bystander action; telecommunicator cardiopulmonary resuscitation (CPR); emergency medical services high-performance CPR; and guideline-based, post-arrest care at hospitals can dramatically improve survival from OHCA; and

Whereas, The 2015 Institute of Medicine report, *Strategies to Improve Cardiac Arrest Survival: A Time to Act*, states that a centralized data registry is fundamental for measuring OHCA incidence and improving OHCA care and survival rates; and

Whereas, The Texas Cardiac Arrest Registry to Enhance Survival (Texas-CARES) Program, an institutional effort to measure OHCA incidence and improve OHCA care and outcomes statewide, was initiated in 2019; therefore be it

RESOLVED, That our American Medical Association investigate the Texas-CARES program with the objective of implementing a similar program in other states or nationwide. (Directive to Take Action)

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

Received: 05/20/21

AUTHOR'S STATEMENT OF PRIORITY

The delegation leadership feels that the program in Texas will be helpful in improving survival from OHCA. We feel it is important that the AMA know of this program and look into helping other states establish a similar program or to develop a nationwide data registry system.

RELEVANT AMA POLICY

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:

- (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
- (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
- (3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
- (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
- (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
- (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
- (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
- (8) supports the development and use of universal connectivity for all defibrillators;
- (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
- (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
- (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
- (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15;

Appended: Res. 211, I-18

Managed Care Organizations' Use of Physicians to Provide Second Opinions to Physicians Providing Emergency Services H-285.950

The AMA adopts the following principles to guide the use by managed care plans of physicians employed or contracted with to specifically provide second opinions to physicians providing emergency services. The AMA encourages managed care plans to follow these guidelines when employing or contracting with physicians to provide second opinions to physicians providing emergency services.

- (1) All managed care plans shall disclose to their enrollees and prospective enrollees any plan requirements or the existence of contractual arrangements whereby physicians are required to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities.
- (2) The required use of physicians to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall not impede the immediate diagnosis and therapy of acute cardiac, trauma, and other critical patient situations for which delay may result in death or an increase in severity of illness.
- (3) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall be licensed to practice medicine and actively practicing emergency medicine in the same state in which the second opinion is provided.

(4) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall have active staff privileges in any facility in which the second opinion is provided.

(5) To the degree possible, patients presenting at an emergency department or facility should be involved in the decisions regarding the treatment, referral, and follow-up care for their condition.

(6) In the event of disagreements over second opinions, final decisions regarding the treatment, referral, and follow-up care provided to patients presenting at emergency departments or facilities shall be made by the attending emergency physician or other appropriate physicians on staff at the facility.

Citation: CMS Rep. 1, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

Standardized Advanced Cardiac Life Support (ACLS) Training for Medical Students D-295.972

Our AMA shall: (1) encourage standardized Advanced Cardiac Life Support (ACLS) training for medical students prior to clinical clerkships; and (2) strongly encourage medical schools to fund ACLS training for medical students.

Citation: (Res. 314, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12)

Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945

Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2) recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support to first-year medical students, preferably during the first term.

Citation: (CCB/CLRPD Rep. 3, A-14)

Cardiac Resuscitation by Nurses H-360.998

With the intent of promoting good patient care, the AMA recognizes the propriety of registered nurses using monitoring, defibrillation, and resuscitative equipment, and instituting immediate life-saving corrective measures, if a licensed physician is not immediately available to do so, providing that: (1) The techniques to be used by a registered nurse in a hospital setting shall have been specified for the hospital by the medical staff on the basis of counsel by a committee representing authoritative medical and nursing opinion; (2) The registered nurse has been competently instructed in the techniques to be used; and (3) The registered nurse performs the authorized procedures: (a) upon the direct order of a doctor of medicine, or (b) pursuant to standing procedures established by the medical staff, these procedures to include provision for immediate summoning of a physician and such other personnel as may be needed.

Citation: Res. 42, I-67; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 09, A-18

Implementation of Automated External Defibrillators in High-School and College Sports Programs D-470.992

Our AMA supports state legislation and/or state educational policies encouraging: (1) each high school and college that participates in interscholastic and/or intercollegiate athletic programs to have an automated external defibrillator and trained personnel on its premises; and (2) athletic coaches, sports medicine personnel, and student athletes to be trained and certified in cardiovascular-pulmonary resuscitation (CPR), automated external defibrillators (AED), basic life support, and recognizing the signs of sudden cardiac arrest.

Citation: Res. 421, A-08; Reaffirmed: CSAPH Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(JUN-21)

Introduced by: American College of Cardiology, American Society of Echocardiography,
Society for Cardiovascular Angiography and Interventions,
Society of Cardiovascular Computed Tomography, American Society of
Nuclear Cardiology

Subject: Sharing Covid-19 Resources

Referred to: Reference Committee F

1 Whereas, The severe acute respiratory syndrome coronavirus 2 (COVID-19) has spread
2 globally, causing nearly 3 million deaths worldwide since first appearing in 2019; and
3

4 Whereas, We express our condolences to all individuals affected by COVID-19 and their
5 families and friends; and
6

7 Whereas, We are grateful for the monumental efforts and sacrifices made by health care
8 professionals, public health workers, research scientists, pharmaceutical companies,
9 government workers, elected officials and others for their continuing contributions in battling this
10 pandemic; and
11

12 Whereas, The phenomenal speed with which effective vaccines against this virus was made
13 possible by basic research grants from the National Institutes of Health and other public
14 institutions, further developed and rapidly manufactured in large quantities by investor-owned
15 pharmaceutical companies; and
16

17 Whereas, Death and other serious complications of COVID infection are more common in
18 individuals with underlying heart disease, diabetes, hypertension and other chronic illnesses;
19 and
20

21 Whereas, The COVID pandemic has unmasked pre-existing severe socioeconomic and racial
22 disparities in the delivery of health care in the United States; and
23

24 Whereas, The public health crisis related to the COVID pandemic is even more deadly in many
25 less economically developed countries around the world; and
26

27 Whereas, COVID vaccine is soon to be available to all Americans desiring to be vaccinated; and
28

29 Whereas, COVID variants continue to appear both in the US and abroad, threatening repeated
30 surges of COVID infections, particularly in those who do not have access to vaccination; and
31

32 Whereas, Resurgence of COVID-19 anywhere in the world potentially affects the United States;
33 and
34

35 Whereas, There is a moral and ethical imperative to provide effective medical care to all
36 patients regardless of their economic status or citizenship; therefore be it

1 RESOLVED, That our American Medical Association call for the cooperation of all governments
 2 and international agencies to share data, research and resources for the production and
 3 distribution of medicines, vaccines and personal protective equipment (Directive to Take
 4 Action); and be it further

5
 6 RESOLVED, That our AMA promote and support efforts to supply COVID vaccines to health
 7 care agencies in other parts of the world to be administered to individuals who can't afford them.
 8 (Directive to Take Action)

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

Received: 05/03/21

AUTHORS STATEMENT OF PRIORITY

The COVID 19 pandemic is seminal public health threat of the past century, of vital importance to all physicians and all patients worldwide. The AMA should continue and expand its leadership role in this arena, particularly updating its policy on the worldwide, equitable distribution of vaccines and other measures which are critical to combating the pandemic.

RELEVANT AMA POLICY

An Urgent Initiative to Support COVID-19 Vaccination Programs D-440.921

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.

Citation: Res. 408, I-20

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.

5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.

Citation: Alt. Res. 404, I-20

World Health Organization H-250.992

The AMA: (1) continues to support the World Health Organization as an institution; (2) advocates full funding as understood by the United States Government for the World Health Organization; (3) will participate in coalitions with other interested organizations to lend its support and expertise to assist the World Health Organization; and (4) encourages the World Medical Association to develop a cooperative work plan with the World Health Organization as expeditiously as possible.

Citation: BOT Rep. 31, A-96; Reaffirmed: CLRPD Rep. 2, A-06; Reaffirmed: CEJA Rep. 03, A-16; Reaffirmed: BOT Rep. 23, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609
(JUN-21)

Introduced by: International Medical Graduates Section
New York

Subject: COVID-19 Crisis in Asia

Referred to: Reference Committee F

1 Whereas, The world has suffered from the pandemic caused by COVID-19, causing the
2 death of millions of people across the globe; and
3

4 Whereas, The USA has been successful in bringing the infection and death rate down; and
5

6 Whereas, After the initial control over the pandemic, multiple countries in Asia including India,
7 Nepal, Thailand, etc. are experiencing a surge of COVID-19 infections and deaths with variants
8 like B.1.617.2 that has overwhelmed the health system to a point where rich and poor, even
9 doctors in the frontlines are dying with lack of basic needs like oxygen; and
10

11 Whereas, The risk of another surge of COVID-19 infection with more virulent strains in the U.S.
12 is more likely unless the pandemic is controlled across the globe; and
13

14 Whereas, Good hearted individuals and physicians, have risen to the occasion, have donated
15 and raised millions of dollars in donations, acquired oxygen concentrators, high flow oxygen
16 devices and respirators and shipped them to those countries; therefore be it
17

18 RESOLVED, That our American Medical Association advocate the U.S. government to continue
19 providing all possible assistance including surplus vaccines and vaccines that have not had
20 Emergency Use Authorization to the citizens of countries with precarious situations in this
21 humanitarian crisis including but not limited to India, Nepal, Thailand, Myanmar, etc. (Directive
22 to Take Action); and be it further
23

24 RESOLVED, That our AMA explore all possible assistance through the World Medical
25 Association and the World Health Organization for the citizens of countries where the cases of
26 COVID-19 have been exponentially increasing (Directive to Take Action); and be it further
27

28 RESOLVED, That our AMA recognize the extraordinary efforts of many dedicated physicians,
29 physician and ethnic organizations assisting in this humanitarian crisis. (Directive to Take
30 Action)

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

Received: 05/31/21

AUTHOR'S STATEMENT OF PRIORITY

The global Covid-19 pandemic has changed everything in our lives, including the way AMA is conducting its business (from in person to virtual). The only way this pandemic will be controlled is by controlling it all over the world and control it NOW. In order to prevent various variants of coronavirus to start a new wave in U.S., we need to take urgent steps now. This resolution is addressing that urgent problem and asks the AMA to be part of the urgent solution. We urge the AMA House of Delegates to consider this resolution for its June meeting.

References:

World Medical Association, <https://www.wma.net/policies-post/wma-council-resolution-in-support-of-the-countries-worst-affected-by-the-covid-19-crisis/>

World Health Organization <https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---18-may-2021>

BBC News, Covid map: Coronavirus cases, deaths, vaccinations by country, <https://www.bbc.com/news/world-51235105>
<https://www.bbc.com/news/world-51235105>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 610
(JUN-21)

Introduced by: Medical Student Section

Subject: Promoting Equity in Global Vaccine Distribution

Referred to: Reference Committee F

1 Whereas, Over half the world's countries have vaccinated less than 1% of their populations, and
2 it is predicted that millions of people in the Global South will not be sufficiently immunized until
3 as late as 2024 ^{1, 2, 3}; and
4

5 Whereas, The European Union, United States, and United Kingdom comprise only 10.8% of the
6 world population yet have given 47% of all vaccinations, while the continent of Africa comprises
7 17.2% of the world population yet only 1.7% of all vaccinations as of 10 April 2021 ^{1, 4}; and
8

9 Whereas, Wealthy countries such as US have secured enough vaccine contracts to vaccinate
10 their populations multiple times over ^{5, 6}; and
11

12 Whereas, The US has administered more vaccine doses than other country (178 million) and is
13 administering more than 3 million doses per day as of 10 April 2021 ¹; and
14

15 Whereas, Inequities in vaccine distribution largely stem from stringent intellectual property (IP)
16 rules implemented at the World Trade Organization (WTO), namely the 1995 Agreement on
17 Trade-Related Aspects of International Property Rights (TRIPS) ⁷; and
18

19 Whereas, TRIPS restricts access to lifesaving therapeutics by mandating that developing low-
20 and middle-income countries (LMIC) who are members of WTO enact monopoly patents on all
21 pharmaceutical inventions, thereby forbidding them from pursuing generic production and
22 distribution of therapeutics ⁷; and
23

24 Whereas, Article 73 of TRIPS allows a WTO member to take "any action which it considers
25 necessary for the protection of its essential security interests... taken in time of war or other
26 emergency in international relations," yet nations' domestic policies lack precedent to invoke
27 such measures ⁴; and
28

29 Whereas, At the October 2020 Council on TRIPS, India and South Africa introduced a proposal
30 calling for a waiver of certain provisions to scale up local generic production of medicines,
31 vaccines, and medical technologies throughout the duration of the COVID-19 pandemic ^{4, 8}; and
32

33 Whereas, 56 countries co-sponsored such a proposal and 120 countries in total support it, but
34 select countries engaged in vaccine nationalism such as the United States have blocked it ⁴;
35 and
36

37 Whereas, The epidemics of HIV/AIDS, tuberculosis, and malaria in South Africa led to the
38 passage of the 2001 Doha Declaration, which states that "the TRIPS Agreement does not and
39 should not prevent Members from taking measures to protect public health," affirming the
40 prioritization of public health over pharmaceutical profits during emergencies ^{9, 10}; and

1 Whereas, Bangladesh has been exempted from TRIPS and not required to grant
2 pharmaceutical patents due to its status as a least-developed country (LDC), and hence the
3 company Beximo bypassed Gilead, independently recreated generic remdesivir, and donated
4 doses to state-run hospitals free of charge without needing to apply for a license ^{11, 12}; and
5

6 Whereas, Most African countries are presently expected to receive enough doses to vaccinate
7 only 5-10% of their populations through the COVAX initiative, an advance purchase scheme
8 founded by the World Health Organization (WHO) that faces challenges due to an opaque
9 financing mechanism and loopholes exploited by wealthy nations ^{13, 14, 15}; and
10

11 Whereas, Years of pioneering, publicly-funded research in government labs and public
12 universities established the groundwork for the technology to develop vaccines for COVID-19,
13 and the unprecedented global public spending for the vaccines has been approximated to be
14 \$100 billion ^{4, 16}; and
15

16 Whereas, Our AMA has previously advocated with interested parties for legislative and
17 regulatory measures that expedite the FDA approval process for generic drugs (H-100.950) ¹⁷;
18 and
19

20 Whereas, Our AMA supports legislation that would prevent inappropriate extension of patent life
21 of pharmaceuticals (D-110.994) ¹⁸; and
22

23 Whereas, Since October 2011, the CDC's Division of Healthcare Quality Promotion (DHQP) has
24 provided state, local and territorial health departments with additional access to data reported by
25 healthcare facilities in their jurisdiction, establishing precedent for a data sharing platform ¹⁹; and
26

27 Whereas, The 2013-2016 Ebola outbreak reaffirmed the need for open sharing of data in public
28 health emergencies and resulted in an agreement to promote global data sharing at a
29 September 2015 WHO consultation ²⁰; and
30

31 Whereas, The WHO has called for member states to voluntarily share data and technology
32 related to the ongoing pandemic through the COVID-19 Technology Access Pool (C-TAP), yet
33 no US manufacturers have entered into such arrangement ²¹; and
34

35 Whereas, Our AMA recognizes that ending the COVID-19 pandemic must require a global
36 concerted effort and as such "strongly supports U.S. and global efforts to fight epidemics and
37 pandemics...and the need for improved public health infrastructure and surveillance in affected
38 countries" (H-440.835) ²²; and
39

40 Whereas, Our AMA likewise "encourages pharmaceutical companies to provide low cost
41 medications to countries during times of pandemic health crises; and shall work with the WHO,
42 UNAID, and similar organizations...to improve public health and national stability" (H-250.988)
43 ²³; and
44

45 Whereas, Our AMA has supported "international campaigns for the prevention of HIV" and
46 "increased availability of antiretroviral drugs and drugs to prevent active tuberculosis infection to
47 countries where HIV/AIDS is pandemic" (H-20.922) ²⁴; and
48

49 Whereas, It is estimated that a 60-80% vaccination rate is required to achieve global herd
50 immunity, and the current global vaccination rate of approximate rate of approximately 6.7
51 million daily doses would take 4.6 years to reach it ²⁵; and

1 Whereas, Failure to achieve equity in vaccination programs and allowing the SARS-CoV-2 virus
2 to further spread and mutate for several more years would wreak havoc on the global economy
3 to the tune of \$9.2 trillion²⁶; and
4

5 Whereas, Our AMA has in the past interfaced with domestic entities on international efforts
6 surrounding global public health, including matters that pertain to world trade and commerce (H-
7 505.964)²⁷; and
8

9 Whereas, Support of global vaccine equity would be a logical extension of our AMA's support of
10 global equity in medication access, and thus is both aligned with and addresses a gap in current
11 policy; therefore be it
12

13 RESOLVED, That our American Medical Association amend policy H-250.988, "Low Cost Drugs
14 to Poor Countries during Times of Pandemic Health Crises," by addition and deletion to read as
15 follows:
16

17 H-250.988 – ~~AID LOW-COST DRUGS TO POOR LOW- AND MIDDLE-INCOME~~
18 ~~COUNTRIES DURING EPIDEMICS AND PANDEMICS~~ TIMES OF PANDEMIC
19 HEALTH CRISES
20

21 Our AMA will: (1) ~~encourages pharmaceutical companies to provide to work with~~
22 governmental and appropriate regulatory authorities to encourage (a) the
23 prioritization of equity when providing low cost or free medications, including
24 therapeutics and vaccines, to countries; (b) the temporary waiver of intellectual
25 property protections for necessary medications and other countermeasures; and (c)
26 sharing of equipment, materials, scientific methods, and technological information, to
27 facilitate production and distribution of necessary medications during epidemics and
28 pandemics during times of pandemic health crises; and (2) shall work with the World
29 Health Organization (WHO), UNAIDS, and similar organizations that provide
30 comprehensive assistance, including health care, to ~~poor~~ low- and middle-income
31 countries in an effort to improve public health and national stability. (Modify Current
32 HOD Policy)

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

Received: 06/06/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be considered at the J21 due to the timeliness of its issue and similarity to another resolution that has already been recommended for consideration.

This resolution calls for the AMA to work with appropriate regulatory authorities that can assure, support, and enforce the temporary suspension of patent rules and the open sharing of the specific blueprints necessary for mass producing vaccines, as well as technical support, medical expertise, and raw materials. This is a substantial addition to existing policy. Of note, the TRIPS waiver has not been implemented. The Biden administration has merely announced plans to negotiate with the WTO and other parties. **This process leaves a critical role for our AMA to ensure that demands reflected in the original proposal are upheld and not weakened.**

Given that HOD Resolution 002, which covers a similar topic but with different goals, was prioritized by the Resolution Committee, this resolution should be too. Based on the priority matrix criteria, this resolution will have deleterious impacts if not addressed at this meeting due to the ongoing status of those negotiations. Delaying discussions on vaccine distribution another 6 months would risk making our AMA's advocacy irrelevant. Time is of the essence and current AMA policy, actions by the White House, nor policy under current consideration at this HOD meeting go far enough.

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RELEVANT AMA POLICY

AMA Role in Addressing Epidemics and Pandemics H-440.835

1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.
 2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members.
 3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.
 4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels.
 5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola.
 6. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.
- Sub. Res. 925, I-14; Reaffirmed: Res. 418, A-17

HIV/AIDS as a Global Public Health Priority H-20.922

In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:

- (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
- (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
- (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
- (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;

- (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
 - (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
 - (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
 - (8) Supports increased availability of antiretroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and
 - (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.
- CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation: I-11; Appended: Res. 516, A-13; Reaffirmation: I-13; Reaffirmed: Res. 916; Modified: Res. 003, I-17

Global Tuberculosis Control H-250.989

Our AMA: (1) recognizes the need for global cooperative efforts to control TB and encourage the establishment of well-supported TB-control programs, especially in countries with a high incidence of TB, founded on the principles of the World Health Organization's Directly Observed Treatment -- Short-course, or DOTS program; and (2) urges Congress to provide adequate funding for the CDC and other public health agencies in order to facilitate global cooperative efforts to control TB.

CSA Rep. I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Low Cost Drugs to Poor Countries During Times of Pandemic Health Crises H-250.988

Our AMA: (1) encourages pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (2) shall work with the World Health Organization (WHO), UNAID, and similar organizations that provide comprehensive assistance, including health care, to poor countries in an effort to improve public health and national stability.

Res. 402, A-02; Reaffirmed: CSAPH Rep. 1, A-12

AMA and Public Health in Developing Countries H-250.986

Our AMA will adhere to a focused strategy that channels and leverages our reach into the global health community, primarily through participation in the World Medical Association and the World Health Organization.

BOT Rep. 5, A-07; Reaffirmed: CSAPH Rep. 01, A-17; Reaffirmed: BOT Rep. 23, A-18

Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers H-100.950

1. Our AMA will advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system.
2. Our AMA supports requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays.
3. Our AMA will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.

Res. 809, I-16

Inappropriate Extension of Patent Life of Pharmaceuticals D-110.994

Our AMA will continue to monitor the implementation of the newly-enacted reforms to the Hatch-Waxman law to see if further refinements are needed that would prevent inappropriate extension of patent life of pharmaceuticals, and work accordingly with Congress and the Administration to ensure that AMA policy concerns are addressed.

BOT Rep. 21, A-04; Reaffirmed: BOT Rep. 19, A-14

Pandemic Preparedness for Influenza H-440.847

In order to prepare for a potential influenza pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.

CSAPH Rep. 5, I-12; Reaffirmation: A-15

International Tobacco Control Efforts H-505.964

Our AMA:

(1) supports the international tobacco control efforts of the World Health Organization and urges the appropriate bodies and persons within the U.S. government (including Congress, the State Department, the Department of Commerce, and the Department of Health and Human Services) to participate fully in international tobacco control efforts, including supporting efforts to bring to fruition a Framework Convention on Tobacco Control;

(2) will work for the enactment of federal legislation or regulations that would prohibit the exportation of tobacco products to other countries. Pending the enactment of such legislation or regulation, our AMA (a) urges the U.S. government to alter trade policies and practices that currently serve to promote the world smoking epidemic; (b) continues to support the following activities: (i) federal legislation requiring health warning labels in the appropriate native language or symbolic form to be on packages of cigarettes exported and require foreign advertising by U.S. tobacco producers to be at least as restrictive as types of advertising permitted in the U.S.; (ii) labeling on tobacco products manufactured abroad to be at least as restrictive as those produced in the U.S.; (iii) opposition to efforts by the U.S. government to

persuade countries to relax regulations concerning tobacco promotion and consumption; and (iv) encouragement of the World Health Organization to increase its worldwide anti-smoking efforts; (c) supports working with the World Medical Association as well as directly with national medical societies to expand activities by the medical profession to reduce tobacco use worldwide; (d) supports establishing close working relations with the World Health Organization to promote more physician involvement in anti-tobacco activities, particularly in developing and recently developed countries; (e) supports working with the Centers for Disease Control and Prevention's Office on Smoking and Health to promote worldwide anti-tobacco activities; (f) supports periodically monitoring the success of worldwide anti-tobacco efforts to control the growing worldwide smoking epidemic; and (g) supports the right of local jurisdictions to enact tobacco regulations that are stricter than those that exist in state statutes and encourages state and local medical societies to evaluate and support local efforts to enact useful regulations; and (3) opposes any efforts by the government or its agencies to actively encourage, persuade or compel any country to import tobacco products and favors legislation that would prevent the government from actively supporting, promoting or assisting such activities.

CSA Rep. 3, A-04; Reaffirmation: I-05; Reaffirmed: CSAPH Rep. 1, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(JUN-21)

Introduced by: Texas

Subject: Insurance Promotion of Preventive Care Services via Incentive-Based Programs

Referred to: Reference Committee G

1 Whereas, Approximately 45% of Americans suffer from at least one chronic disease; and

2
3 Whereas, 34% of heart disease deaths, 21% of cancer deaths, and 39% of chronic lower
4 respiratory deaths from 2008 to 2011 were preventable; and

5
6 Whereas, In 2015, only 8% of U.S. adults aged 35 and older had received all high-priority,
7 clinical preventive services; and

8
9 Whereas, Small cash incentives to patients have shown to improve primary care visits, and, as
10 a result, improve screening for preventable health conditions; and

11
12 Whereas, 79% of commercially available health insurance plans offered members incentives for
13 receiving specific clinical preventive services; and

14
15 Whereas, 49% of commercial health insurance plans found incentives useful for uptake of
16 preventive health care services; and

17
18 Whereas, Texas created the Wellness Incentives and Navigation project funded by the
19 Medicare Incentives for Prevention of Chronic Disease (MIPCD) program, which from 2011 to
20 2015 monetarily incentivized use of health promotion programs to prevent diseases such as
21 diabetes, heart disease, and hyperlipidemia; and

22
23 Whereas, 76% of MIPCD program beneficiaries nationwide reported participation encouraged
24 lifestyle changes such as setting goals and working toward improving their health; therefore be it

25
26 RESOLVED, That our American Medical Association advocate for health insurance companies
27 to adopt cash-based incentive programs similar to the Medicare Incentives for Prevention of
28 Chronic Disease program to promote usage of preventive care services (Directive to Take
29 Action); and be it further

30
31 RESOLVED, That AMA support further research on health care initiatives that increase usage of
32 preventive care services. (New HOD Policy)

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

Received: 05/20/21

AUTHOR'S STATEMENT OF PRIORITY

Delegation leadership testified at the TMA reference committees that AMA has good policy which covers this resolution and AMA considers resolutions which are reaffirmation of current policy with little to no change as "Not a Priority Resolution" and probably will not be considered at the June 2021 Special Meeting. The TMA House of Delegates felt it should still be referred to the AMA because it is such an important issue.

References:

1. Raghupathi W, Raghupathi V. An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach. *Int J Environ Res Public Health*. 2018;15(3):431. doi:10.3390/ijerph15030431.
2. McCarthy M. Up to 40% of premature deaths in the US are preventable, says CDC. *BMJ* 2014; 348:g3122.
3. Borsky A, Zhan C, Miller T, Ngo-Metzger Q, Bierman AS, Meyers M. Few Americans Receive All High-Priority, Appropriate Clinical Preventive Services. *Health Affairs* 2018 37:6, 925-92.
4. Bradley CJ, Neumark D. Small Cash Incentives Can Encourage Primary Care Visits By Low-Income People With New Health Care Coverage. *Health Affairs* 2017 36:8, 1376-1384.
5. Higgins A, Fahey K, Veselovskiy G. [Prevention and Wellness Programs of Commercial Health Insurance Plans](#). America's Health Insurance Plans. June 2017.
6. *Medicaid Incentives for Prevention of Chronic Diseases*. Center for Medicare and Medicaid Services. <https://downloads.cms.gov/files/cmmi/mipcd-finalevalrpt.pdf>. April 2017.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(JUN-21)

Introduced by: Texas

Subject: Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated
Improved Patient Outcomes or Overall Cost Savings

Referred to: Reference Committee G

1 Whereas, Step-edit therapy--also known as a "fail first" policy--is used by insurance companies
2 as a form of prior authorization that dictates a required first line of drug therapy for a patient, and
3 defines first-line drugs as preferred and designated as Tier 1, while nonpreferred drugs are
4 designated as Tier 2 or Tier 3, with copays for nonpreferred drugs in Tier 2 higher than in Tier 1
5 and highest in Tier 3; and
6

7 Whereas, Studies have shown patients underutilize therapeutic drugs when a copay is higher,
8 with a nonadherence rate as high as 52% for antihypertensive drugs and with similar results of
9 nonadherence for antidepressants, nonsteroidal anti-inflammatory drugs, and antidiabetic drugs;
10 and
11

12 Whereas, Although the underutilized drugs have demonstrated a cost savings on drugs, studies
13 have shown an increase in medical cost; however, overall costs savings have been shown to
14 occur when medicines were affordable without a tier system; therefore be it
15

16 RESOLVED, That our American Medical Association urge our legislators to review and make
17 transparent the "fail-first" policy of step-edit therapy and study how it affects patient outcomes.
18 (New HOD Policy)

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

Received: 05/20/21

AUTHOR'S STATEMENT OF PRIORITY

The purpose of this resolution is to re-focus our attention on how the practice of step-edit therapy also known as first-fail policies practiced by insurers and/or their pharmacy benefits managers (PBMs) is impacting access to care and worse yet how it is dictating to the physician on how to treat their patients. In other words, it is the practice of medicine without establishing what we cherish most, a patient-doctor relationship.

The data on this policy (Step-Edit) clearly demonstrates when implemented non-adherence to medical care rises. Step-Edit policies also have a Tier system with increasing co-pays. The total cost of medicines for the insurer is lower when utilized, however; the total cost of medical care that follows rises. There is also data showing the total cost of medical care is lower without a Tier system.

Step-Edit therapy policy is unethical at the very least and we as medical providers should not acknowledge this policy as an acceptable norm in the practice of medicine.

Delegation leadership testified at the TMA reference committees that AMA has good policy which covers this resolution and AMA considers resolutions which are reaffirmation of current policy with little to no change as "Not a Priority Resolution" and probably will not be considered at the June 2021 Special Meeting. The TMA House of Delegates felt it should still be referred to the AMA because it is such an important issue.

RELEVANT AMA POLICY

Step Therapy D-320.981

1. Our AMA believes that step therapy programs create barriers to patient care and encourage health plans to instead focus utilization management protocol on review of statistical outliers.
2. Our AMA will advocate that health plan step therapy protocols, if not repealed, should feature the following patient protections:
 - a. Enable the treating physician, rather than another entity such as the insurance company, to determine if a patient “fails” a treatment;
 - b. Exempt patients from the step therapy protocol when the physician believes the required step therapy treatments would be ineffective, harmful, or otherwise against the patients’ best interests;
 - c. Permit a physician to override the step therapy process when patients are stable on a prescribed medication;
 - d. Permit a physician to override the step therapy if the physician expects the treatment to be ineffective based on the known relevant medical characteristics of the patient and the known characteristics of the drug regimen; if patient comorbidities will cause, or will likely cause, an adverse reaction or physical harm to the patient; or is not in the best interest of the patient, based on medical necessity;
 - e. Include an exemption from step therapy for emergency care;
 - f. Require health insurance plans to process step therapy approval and override request processes electronically;
 - g. Not require a person changing health insurance plans to repeat step therapy that was completed under a prior plan; and
 - h. Consider a patient with recurrence of the same systematic disease or condition to be considered an established patient and therefore not subject to duplicative step therapy policies for that disease or condition.

Citation: Res. 714, A-19; Modified: Res. 815, I-19

Step Therapy H-320.937

Our AMA actively supports state and federal legislation that would allow timely clinician-initiated exceptions to, and place reasonable limits on, step therapy protocols imposed by health care plans.

Citation: Res. 815, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(JUN-21)

Introduced by: Young Physicians Section

Subject: Opposition to Elimination of “Incident-to” Billing for Non-Physician Practitioners

Referred to: Reference Committee G

Whereas, On May 1, 2021, UnitedHealthcare in Texas formally changed its payment policy regarding non-physician practitioners (NPP) including nurse practitioners and physician assistants, requiring billing under their own National Provider Identifier (NPI);¹ and

Whereas, This change, implemented over the objections of the state medical society, will reduce payment to practices by 15% through the de facto elimination of payments “incident-to” physician-initiated services; and

Whereas, This 15% payment cut for services provided by NPPs in the context of physician-led care is damaging to medical practices, particularly those affected by losses related to the COVID-19 pandemic; and

Whereas, The concept of independent service by an NPP is illogical in the context of many subspecialty fields such as medical oncology and radiation oncology; and

Whereas, The Medicare Payment Advisory Commission has recommended as recently as 2019 the elimination of “incident-to” billing;² therefore be it

RESOLVED, That our American Medical Association advocate against efforts to eliminate “incident-to” billing for non-physician practitioners among private and public payors. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 06/05/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution asks for the AMA to take a stand against the removal of incident-to billing. This resolution is timely as United Healthcare just changed in payment policy May 1, 2021. It impacts many physician practices who use non-physician providers in the context of a physician-led team. Physician practices are at risk of a 15% payment cut, which is of high priority to this organization. Finally, this touches on scope of practice issues, which is also of high priority. Given it fits squarely within our mission/strategic plan, no current policy on this exists, AMA action will have a positive impact, and the AMA is most appropriate to tackle this issue, we feel this is a top priority resolution.

References:

(1) <https://www.uhcprovider.com/content/dam/provider/docs/public/policies/exchange-reimbursement/erpub/UHC-Exchange-RPUB-MAR-2021.pdf>

(2) http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Lawrence “Larry” Monahan, MD

Introduced by the Organized Medical Staff Section

Whereas, After a long and distinguished career in internal medicine, Lawrence “Larry” Monahan, MD, passed away on November 23, 2020, at age 79; and

Whereas, Dr. Monahan was highly regarded by his colleagues, patients, friends, and family as a careful, kind, and caring physician, an excellent teacher, and a role model for medical students, interns, and residents; and

Whereas, After having received his B.A. Degree from Kansas State University and his M.D. from the University of Kansas School of Medicine, Dr. Monahan came to adopt the state of Virginia as his home following his internship in Roanoke and eventually establishing his practice in Roanoke and Salem; and

Whereas, Dr. Monahan was an active member of the United States Navy Reserve for 30 years, serving on active duty in Vietnam and stateside from 1970-1972, eventually achieving the rank of Captain in the Medical Core and returning to active duty during Operation Desert Shield/Storm from 1990-1991 before retiring in 1999; and

Whereas, Dr. Monahan was dedicated to his students and the study of medicine in his positions of Clinical Professor of Internal Medicine at both the University of Virginia School of Medicine in Roanoke and the Virginia College of Osteopathic Medicine in Blacksburg; and

Whereas, Dr. Monahan’s commitment to the practice of medicine was reflected in his position as a Fellow of the American College of Physicians, his numerous publications in state and national medical journals, and receiving the American Medical Association’s Continuing Medical Education Award every year of his practice; and

Whereas, Dr. Monahan’s engagement in organized medicine began with his local community, serving as Chairman of the Board of Directors of the Roanoke Valley Academy of Medicine and President of the Virginia Society of Internal Medicine; and

Whereas, That engagement continued at the state medical society level, with Dr. Monahan serving as a member of the Medical Society of Virginia (MSV) for 46 years, during which time he was a Delegate to the annual meeting of the House of Delegates of the MSV for 43 years, actively participated on the Medical Society of Virginia Political Action Committee and Medical Society of Virginia Foundation boards, and distinguished himself in prominent leadership roles including Speaker of the House, First Vice President, and President of the MSV; and

Whereas, Dr. Monahan was a lifetime member of our AMA and a valued AMA leader, serving as a Delegate to the AMA House of Delegates from the state of Virginia for more than 30 years and attending each Annual and Interim meeting during that time; and

Whereas, Dr. Monahan was an active member of the Organized Medical Staff Section, representing his hospital for more than 30 years, serving as State Chair, and most recently serving as Member at-Large on the OMSS Governing Council; and

Whereas, Dr. Monahan was a life-long devotee to music, both in study and in performance as an organist, as well as an accomplished competitive ballroom dancer and outdoor enthusiast; and

Whereas, Dr. Monahan was a loving and devoted husband to his wife, Davida, father to daughter Ashley and son Evan, and grandfather to Payton, Alex, and Aiden, and a true friend and boon companion to all who met him; therefore be it

RESOLVED, That our American Medical Association acknowledge with deep gratitude and sincere appreciation the lifelong work performed by Lawrence Monahan, MD, in service of the practice of medicine; and be it further

RESOLVED, That our AMA extend its heartfelt condolences to the family of Lawrence Monahan, MD, and adopt this resolution as an expression of deepest respect for our colleague and dear friend and our grief at his passing.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Lawrence Keith Monahan, M.D. FACP

Introduced by Virginia

Whereas, Dr. Larry Monahan was not only a truly gifted clinician who served his community by his practice in general internal medicine in Roanoke, Virginia, he was a true physicians' advocate by his lifelong service to organized medicine at multiple levels; and

Whereas, Dr. Monahan served graciously as speaker and past president of the Medical Society of Virginia and an overall member of the Medical Society of Virginia for 43 years. Dr. Monahan taught with compassion and care at the University of Virginia School of Medicine and the Virginia College of Osteopathic Medicine as a clinical professor of internal medicine; and

Whereas, Dr. Monahan was well known at our American Medical Association and served honorably for many years as an AMA Delegate, serving 22 years in the Organized Medical Staff Section (OMSS); and

Whereas, Dr. Monahan was a Fellow of the American College of Physicians where he received the American Medical Association's Continuing Medical Education Award every year of his practice; and

Whereas, Larry was a gifted physician, an extraordinarily kind individual, and the best ballroom dancer; and

Whereas, He was known as an excellent teacher and a true believer in advocating for his patients; and

Whereas, His colleagues at our AMA shall miss his balanced perspective, leadership and contagious smile; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the many contributions made by Dr. Lawrence K. Monahan to the medical profession, as well the encompassing Virginia community; and be it further

RESOLVED, That our AMA House of Delegates express its sympathy for the death of Dr. Monahan to his family and present them with a copy of this resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Paul James O'Leary, MD

Introduced by Alabama

Whereas, Paul J. O'Leary, MD, a psychiatrist who practiced forensic psychiatry and child and adolescent psychiatry in Birmingham, Alabama, passed away suddenly on May 12, 2021; and

Whereas, Dr. O'Leary graduated summa cum laude from the University of Alabama in Birmingham with a bachelor's degree in Chemistry and later earned a master's degree in Health Informatics; and

Whereas, Dr. O'Leary graduated from the University of Alabama School of Medicine, and continued his post-graduate education through a psychiatry residency and a child and adolescent psychiatry fellowship at the University of Alabama School of Medicine; and

Whereas, Dr. O'Leary also completed a forensic psychiatry fellowship at Emory University; and

Whereas, Dr. O'Leary was highly respected by physicians and other healthcare professionals for his expertise and dedication to his patients; and

Whereas, Dr. O'Leary was active in many local and state psychiatric organizations, serving as president of the Birmingham Psychiatric Society and as a member of the Legislative and Public Affairs Committee for the Alabama Psychiatric Physicians Association; and

Whereas, Dr. O'Leary was also active in the Medical Association of the State of Alabama, where he served as chair of the Young Physicians' Section and the YPS member of the Board of Censors; and

Whereas, Dr. O'Leary was Vice Speaker of the Medical Association of the State of Alabama's House of Delegates and College of Counsellors at the time of his death; and

Whereas, Dr. O'Leary also served as the Speaker of the Assembly of the American Psychiatric Association; and

Whereas, Dr. O'Leary had been a member of the American Medical Association's House of Delegates since first attending as a Resident and Fellows Section Delegate; and

Whereas, Dr. O'Leary continued his contributions to the American Medical Association as an alternate delegate and delegate, representing the American Psychiatric Association from 2011 until the time of his death; and

Whereas, Dr. O'Leary was, above all else, a devoted husband and father to his wife, Malinda and his daughters Sophia and Sylvia and will be greatly missed by his parents, brother, family and friends; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Dr. Paul J. O'Leary's outstanding service to the profession; and be it further

RESOLVED, That a copy of this resolution be recorded in the proceedings of this House and be forwarded to Dr. O'Leary's family with an expression of the House's deepest sympathy.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Barbara A. P. Rockett, MD

Introduced by Massachusetts

Whereas, Dr. Barbara A. P. Rockett passed away on Tuesday, April 13, 2021, at the age of 89 and was a member of the American Medical Association for over 35 years and the Massachusetts Medical Society for over 40 years; and

Whereas, Dr. Rockett graduated from Tufts University School of Medicine in 1957; and

Whereas, Dr. Rockett was the first female surgical resident at Boston City Hospital and practiced general surgery; and

Whereas, Dr. Rockett was the beloved wife to Francis X. Rockett, MD, for 63 years and devoted mother of Francis X. Jr., Peter S., William E., Sean E., and Julie Rockett; and

Whereas, Dr. Rockett participated in organized medicine at the local, state, and national levels and dedicated herself to physicians and patients, whether performing house calls or speaking on the Senate floor, and she was stellar in all her abilities; and

Whereas, Dr. Rockett was chair of the AMA Council on Legislation, an active member of the House of Delegates for over 30 years, and president of the AMA Foundation; and

Whereas, Dr. Rockett was the first woman MMS president and the only president in modern time to serve two terms. During that time, Massachusetts was going through a medical malpractice crisis and Barbara was the lead. Being very effective, she was approached to stay on another term to continue her great work. Dr. Rockett secured malpractice reforms that are still benefiting our colleagues today; and

Whereas, Dr. Rockett received numerous awards over her illustrious career including the AMA Young Physicians' Young at Heart Award, the United Nations-USA Distinguished Service Award, the St. Francis Medal of Peace & Achievement, and the Tufts University Distinguished Service Award. Within the MMS, she received the Grant V. Rodkey, MD Award for Outstanding Contributions to Medical Education, sponsored by the Medical Student Section, the Presidential Citation for Outstanding Leadership, Award for Distinguished Service to the Massachusetts Medical Society, the Lifetime Achievement Award, the Norfolk District Medical Society's Clinician of the Year Award, and the Norfolk District Lifetime Achievement Award. Dr. Rockett was particularly proud of the most recent award named in her honor by the Committee on Young Physicians, the Barbara A. Rockett, MD, Early Career Physician Leadership Award, recognizing an early career physician who has demonstrated exemplary leadership in organized medicine, patient advocacy, and mentorship; and

Whereas, Dr. Barbara Rockett will be remembered as a courageous advocate for the most vulnerable people in society and as an articulate voice for ethical medical care. She is known as a champion physician who respects the life and dignity of every human being; therefore be it

RESOLVED, That our American Medical Association acknowledge the natural death and celebrate the life of our dear friend and colleague Barbara A. P. Rockett, MD; and be it further

RESOLVED, That expressions of condolences be forwarded with a copy of this memorial resolution to the Rockett family.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Calvin C.J. Sia, MD, FAAP

Introduced by the American Academy of Pediatrics

Whereas, The American Academy of Pediatrics (AAP) lost a respected and valued member when Calvin C.J. Sia MD, FAAP, passed away on August 19, 2020, in Honolulu, Hawaii; and

Whereas, Dr. Sia is the father of the medical home concept of care and Emergency Medical Services for Children Program; and

Whereas, Dr. Sia recognized challenges within his community and he sought ways to solve those challenges, and then brought those solutions not only to the community, but state, national, and even global level; and

Whereas, Dr. Sia advocated for children across the scope of pediatrics, including children with disabilities, emergency services for children, child abuse prevention and early periodic screening, diagnosis and treatment standards; and

Whereas, Dr. Sia served on the advisory committee for the Anne E. Dyson Foundation's initiative for pediatric residency training in community pediatrics; and

Whereas, Dr. Sia developed a home visiting program to prevent child abuse and neglect among children with special health care needs; and

Whereas, Dr. Sia introduced the Hawaii Healthy Start Home Visitors Program, he brought the model to the nation as Healthy Families America; and

Whereas, While Dr. Sia was president of the Hawaii Medical Association (1976-77), he worked on expanding the quality of emergency care provided to children with injuries where responders were not equipped for children, and urged the AAP to support a system of emergency medical care for children which resulted in the Emergency Medical Services for Children (EMS) Act, enacted in 1984; and

Whereas, Dr. Sia's passion and persistence brought our AMA and the AAP together to advance child health issues; and

Whereas, In 2007, the AAP, American Academy of Family Physicians, American College of Physicians and the American Osteopathic Association adopted the Joint Principles of the Patient-Centered Medical Home; and

Whereas, Throughout Dr. Sia's career he has earned numerous honors, including the Barbara Starfield Primary Care Leadership Award, Clifford G. Grulee Award, Job Lewis Smith Award, AMA Benjamin Rush Award, and the AMA/AAP Abraham Jacobi Award; and

Whereas, In 2005 the AAP Council on Community Pediatrics established the Calvin C.J. Sia Community Pediatrics Medical Home Leadership and Advocacy Award; therefore be it

RESOLVED, That our American Medical Association recognize and honor the many significant contributions made by Dr. Calvin C.J. Sia, MD, FAAP.

SUMMARY OF FISCAL NOTES (JUNE 2021)

BOT Report(s)

- 01 Annual Report: None
- 02 2020 Grants and Donations: Informational report
- 03 AMA 2022 Dues: No significant fiscal impact
- 04 Update on Corporate Relationships: Informational report
- 05 AMA Performance, Activities and Status in 2020: Informational report
- 06 Annual Update on Activities and Progress in Tobacco Control: March 2020 Through February 2021: Informational report
- 07 Council on Legislation Sunset Review of 2011 House Policies: Minimal
- 08 Plan for Continued Progress Toward Health Equity (Center for Health Equity Annual Report): Informational report
- 09 Preservation of the Patient-Physician Relationship: None
- 10 Protestor Protections: Minimal
- 11 Redefining the AMA's Position on ACA and Healthcare Reform: Informational report
- 12 Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment: Modest
- 13 Amending the AMA's Medical Staff Rights and Responsibilities: Minimal
- 14 Pharmaceutical Advertising in Electronic Health Record Systems: Minimal
- 15 Removing Sex Designation from the Public Portion of the Birth Certificate: Minimal
- 16 Follow-up on Abnormal Medical Test Findings: Minimal
- 17* Specialty Society Representation in the House of Delegates - Five-Year Review: Minimal
- 18* Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19: Minimal

CC&B Report(s)

- 01* Bylaw Accuracy: Single Accreditation Entity for Allopathic and Osteopathic Graduate Medical Education Programs: Minimal
- 02* AMA Women Physicians Section: Clarification of Bylaw Language: Minimal
- 03* Clarification to Bylaw 7.5.2, Cessation of Eligibility (for the Young Physicians Section): Minimal

CEJA Opinion(s)

- 01* Amendment to Opinion 1.2.2, "Disruptive Behavior and Discrimination by Patients: Informational Report
- 02* Amendment to Opinion 8.7, "Routing Universal Immunization of Physicians": Informational Report

CEJA Report(s)

- 01* CEJA's Sunset Review of 2011 House Policies: Minimal
- 02* Short-term Medical Service Trips: Minimal
- 03* Amendment to Opinion E-9.3.2, "Physician Responsibilities to Impaired Colleagues": Minimal
- 04* Augmented Intelligence & the Ethics of Innovation in Medicine: Informational Report
- 05* Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report: Informational Report

CLRPD Report(s)

- 01* Demographic Characteristics of the House of Delegates and AMA Leadership: Informational Report

CME Report(s)

- 01* Council on Medical Education Sunset Review of 2011 House Policies: Minimal
- 02* Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses: Minimal

SUMMARY OF FISCAL NOTES (JUNE 2021)

CME Report(s)

- 03* Optimizing Match Outcomes: Minimal
- 04* Expediting Entry of Qualified IMG Physicians to U.S. Medical Practice: Minimal
- 05* Promising Practices Among Pathway Programs to Increase Diversity in Medicine: Modest

CMS Report(s)

- 01* Council on Medical Service's Sunset Review of 2011 House Policies: Minimal
- 02* Continuity of Care for Patients Discharged from Hospital Settings: Minimal
- 03* Universal Basic Income Pilot Studies: Minimal
- 04* Promoting Accountability in Prior Authorization: Minimal
- 05# Medical Center Patient Transfer Policies (REVISED): Minimal
- 06* Urgent Care Centers: Minimal
- 07* Addressing Equity in Telehealth: Minimal
- 08* Licensure and Telehealth: Modest
- 09* Addressing Payment in Delivery in Rural Hospitals: Minimal

CSAPH Report(s)

- 01* Council on Science and Public Health Sunset Review of 2011 House Policies: Minimal
- 02* Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings: Minimal
- 03# Addressing Increases in Youth Suicide (REVISED): Minimal

Joint Report(s)

- 01* CCB/CLRPD Joint Council Sunset Review of 2011 House Policies: Minimal

Report of the Speakers

- 01 Recommendations for Policy Reconciliation: Informational report
- 02 Report of the Election Task Force: Up to \$250,000 if AMA elects to sponsor a reception, depending on the number of people and food and beverage.

Resolution(s)

- 001 Discrimination Against Physicians Treated for Medication Opioid Use Disorder (MOUD): Modest
- 002 Sharing Covid-19 Resources - MOVED TO REF COMM F (NOW 608): Modest
- 003* Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions: Minimal
- 004* AMA Resident/Fellow Councilor Term Limits: Minimal
- 005* Resident and Fellow Access to Fertility Preservation: Modest
- 006* Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients: Modest
- 007* Nonconsensual Audio/Video Recording at Medical Encounters: Minimal
- 008* Organ Transplant Equity for Persons with Disabilities: Modest
- 009* Supporting Women and Underrepresenting Minorities in Overcoming Barriers to Positions of Medical Leadership and Competitive Specialties: Moderate
- 010* Updated Medical Record Policy Regarding Physicians with Suspended or Revoked Licenses: Minimal
- 011* Truth, Reconciliation and Healing in Medicine and Medical Education: Estimated cost of \$320K to implement resolution includes salaries and wages, professional fees, travel and meetings, promotion and publication costs.
- 012* Increasing Public Umbilical Cord Blood Donations in Transplant Centers: Modest

SUMMARY OF FISCAL NOTES (JUNE 2021)

Resolution(s)

- 013* Combatting Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism: Modest
- 014* Supporting the Study of Reparations as a Means to Reduce Racial Inequalities: Moderate
- 015* Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender-Affirming Care for Transgender and Gender-Diverse Individuals: Minimal
- 016* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers: Minimal
- 017* Improving the Health and Safety of Sex Workers: Minimal
- 018* LGBTQ+ Representation in Medicine: Moderate
- 019* Evaluating Scientific Journal Articles for Racial and Ethnic Bias: Modest
- 020* Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954: Minimal
- 021* Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions: Minimal
- 022# Maternal Levels of Care Standards of Practice: Modest
- 023# Pandemic Ethics and the Duty of Care: Minimal
- 024# AMA Bylaws Language on AMA Young Physicians Section Governing Council Eligibility: Minimal
- 101 Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits: Modest
- 102 Bundling Physician Fees with Hospital Fees: Minimal
- 103 COBRA for College Students: Modest
- 104 Medicaid Tax Benefits: Modest
- 105 Effects of Telehealth Coverage and Payment Parity on Health Insurance Premiums: Estimated cost of \$260,000. The specific action planned if adopted would be to hire a research/consulting firm to develop different scenarios based on a range of utilization changes (e.g., what is new, and what is just a shift from in-person) and downstream effects
- 106 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?: Modest
- 107* Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance: Minimal
- 108* Implant Associated Anaplastic Large Cell Lymphoma: Minimal
- 109* Support for Universal Internet Access: Modest
- 110* Healthcare Marketplace Plan Selection: Modest
- 111* Towards Prevention of Hearing-Loss Associated Cognitive Impairment: Modest
- 112* Fertility Preservation Benefits for Active-Duty Military Personnel: Modest
- 113* Support for Universal Internet Access: Modest
- 114* Reimbursement of School-Based Health Centers: Minimal
- 115* Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration: Modest
- 116* Caps on Insulin Co-Payments for Patients with Insurance: Minimal
- 117* Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System: Modest
- 118# Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient: Modest
- 119# Caps on Insulin Copayments with Insurance: Minimal
- 120# Postpartum Maternal Healthcare Coverage Under Children's Insurance: Modest
- 121# Medicaid Dialysis Policy for Undocumented Patients: Modest
- 122# Developing Best Practices for Prospective Payment Models: not yet determined
- 123# Medicare Eligibility at Age 60: not yet determined
- 201 Ensuring Continued Enhanced Access to Healthcare via Telemedicine and Telephonic Communication: Modest
- 202 Prohibit Ghost Guns: Minimal
- 203 Ban the Gay/Trans (LGBTQ+) Panic Defense: Modest
- 204 Insurers and Vertical Integration: Modest

SUMMARY OF FISCAL NOTES (JUNE 2021)

Resolution(s)

- 205 Protection of Peer-Review Process: Modest
- 206* Redefining the Definition of Harm: Modest
- 207* Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education: Estimated cost of \$100,000 for staff expenses and consultant fees.
- 208* Increasing Residency Positions for Primary Care: Modest
- 209* Making State Health Care Cost Containment Council Datasets Free of Cost and Readily Available for Academic Research: Modest
- 210* Ransomware and Electronic Health Records: Modest
- 211* Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-Dose Medications for Multiple Patients: Modest
- 212* ONC's Information Blocking Regulations: Modest
- 213* CMMI Payment Reform Models: Modest
- 214* Status of Immigration Laws, Rules, and Legislation During National Crises and Addressing Immigrant Health Disparities: Minimal
- 215* Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs: Minimal
- 216* Opposition to Federal Ban on SNAP Benefits for Persons Convicted of Drug Related Felonies: Minimal
- 217* Amending H-150.962, Quality of School Lunch Program to Advocate for the Expansion and Sustainability of Nutritional Assistance Programs During COVID-19: Minimal
- 218* Advocating for Alternatives to Immigrant Detention Centers that Respect Human Dignity: Modest
- 219* Oppose Tracking of People who Purchase Naloxone: Minimal
- 220* Equal Access to Adoption for the LGBTQ Community: Minimal
- 221* Support for Mental Health Courts: Minimal
- 222* Advocating for the Amendment of Chronic Nuisance Ordinances: Minimal
- 223* Supporting Collection of Data on Medical Repatriation: Modest
- 224* Using X-Ray and Dental Records for Assessing Immigrant Age: Minimal
- 225# Insurance Coverage Transparency: Modest
- 226# Interest-Based Debt Burden on Medical Students and Residents: Modest
- 227# Audio-Only Telehealth for Risk Adjusted Payment Models: not yet determined
- 228# COVID-19 Vaccination Rollout to Emergency Departments and Urgent Care Facilities: not yet determined
- 229# Classification and Surveillance of Maternal Mortality: not yet determined
- 230# Considerations for Immunity Credentials During Pandemics and Epidemics: not yet determined
- 231# Increasing Access to Menstrual Hygiene Products: not yet determined
- 232# Preventing Inappropriate Use of Patient Protected Medical Information in the Vaccination Process: not yet determined
- 301 Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic: Modest
- 302 Non-Physician Post-Graduate Medical Training: Modest
- 303 Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE: Modest
- 304* Decreasing Financial Burdens on Residents and Fellows: Minimal
- 305* Non-Physician Post-Graduate Medical Training: Modest
- 306* Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training: Minimal
- 307* Updating Current Wellness Policies and Improving Implementation: Minimal
- 308* Rescind USMLE Step 2 CS and COMLEX Level 2 PE Examination Requirement for Medical Licensure: Minimal
- 309* Supporting GME Program Child Care Residency Training: Modest
- 310* Unreasonable Fees Charged and Inaccuracies by the American Board of Internal Medicine: Minimal
- 311* Student Loan Forgiveness: Modest

SUMMARY OF FISCAL NOTES (JUNE 2021)

Resolution(s)

- 312* AMA Support for Increased Funding for the American Board of Preventive Medicine Residency Programs: Minimal
- 313* Fatigue Mitigation Respite for Faculty and Residents: Minimal
- 314* Standard Procedure for Accommodations in USMLE and NBME Exams: Modest
- 315* Representation of Dermatological Pathologies in Varying Skin Tones: Minimal
- 316* Improving Support and Access for Medical Students with Disabilities: Modest
- 317# Medical Honor Society Inequities and Reform: Modest
- 318# The Impact of Private Equity on Medical Training: Modest
- 319# The Effect of the COVID-19 Pandemic on Graduate Medical Education: Minimal
- 401 Universal Access for Essential Public Health Services: Modest
- 402 Modernization and Standardization of Public Health Surveillance Systems: Modest
- 403* Confronting Obesity as a Key Contributor to Maternal Mortality, Racial Disparity, Death from Covid-19, Unaffordable Health Care Cost while Restoring Health in America: Estimated cost of up to \$660K annually to implement this resolution. Estimate includes costs for additional and current staffing, travel and meetings, professional fees, marketing planning and promotion, communications and report development.
- 404* Support for Safe and Equitable Access to Voting: Minimal
- 405* Traumatic Brain Injury and Access to Firearms: Modest
- 406* Attacking Disparities in Covid-19 Underlying Health Conditions: Minimal
- 407* Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities: Modest
- 408* Screening for HPV-Related Anal Cancer: Minimal
- 409* Weapons in Correctional Healthcare Settings: Modest
- 410* Ensuring Adequate Health Care Resources to Address the Long COVID Crisis: Modest
- 411* Ongoing Use of Masks by and Among High-Risk Individuals to Reduce the Risk of Spread of Respiratory Pathogens: Modest
- 412* Addressing Maternal Discrimination and Support for Flexible Family Leave: Minimal
- 413* Call for Increased Funding and Research for Post Viral Syndromes: Modest
- 414* Call for Improved Personal Protective Equipment Design and Fitting: Minimal
- 415* Amending H-440.847 to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles: Minimal
- 416* Expansion on Comprehensive Sexual Health Education: Minimal
- 417* Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925: Minimal
- 418* Reducing Disparities in HIV Incidence Through Pre-Exposure Prophylaxis (PrEP) for HIV: Minimal
- 419* Student-Centered Approaches for Reforming School Disciplinary Policies: Minimal
- 420# Impact of Social Networking Services on the Health of Adolescents: Moderate
- 421# Medical Misinformation in the Age of Social Media: not yet determined
- 501 Ensuring Correct Drug Dispensing: Minimal
- 502 Scientific Studies Which Support Legislative Agendas: Minimal
- 503 Access to Evidence-Based Addiction Treatment in Correctional Facilities: Minimal
- 504* Healthy Air Quality: Minimal
- 505* Personal Care Product Safety: Modest
- 506* Wireless Devices and Cell Tower Health and Safety: Minimal
- 507* Evidence-Based Deferral Periods for MSM Donors for Blood, Corneas and Other Tissues: Minimal
- 601* \$100 Member Annual Dues Payment Through 2023: Cost to implement this resolution of \$20.9 million annually.
- 602* Timely Promotion and Assistance in Advance Care Planning and Advance Directives: Moderate

SUMMARY OF FISCAL NOTES (JUNE 2021)

Resolution(s)

- 603* AMA Urges Health and Life Insurers to Divest from Investments in Fossil Fuels: Moderate
- 604* Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis: \$7,250,000 to create a new climate crisis center charged with determining the highest-yield advocacy and leadership opportunities for physicians, and for coordinating, strengthening and centralizing our AMA's efforts toward advocating for an equitable and inclusive transition to a net-zero carbon society by 2050. The fiscal note includes salaries, wages, travel, meetings, professional fees, and promotion.
- 605* Amending G-630.140, Lodging, Meeting Venues and Social Functions: Minimal
- 606* AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations: Minimal
- 607# Support for Texas-CARES Program: Minimal
- 608# Sharing Covid-19 Resources: Modest
- 609# COVID-19 Crisis in Asia: Modest
- 610# Promoting Equity in Global Vaccine Distribution: Minimal
- 701 Physician Burnout is an OSHA Issue: Modest
- 702 Addressing Inflammatory and Untruthful Online Ratings: Minimal
- 703 Employed Physician Contracts: Minimal
- 704 Eliminating Claims Data for Measuring Physician and Hospital Quality: Modest
- 705* Improving the Prior Authorization Process: Modest
- 706* Prevent Medicare Advantage Plans from Limiting Care: Modest
- 707* Financial Incentives for Patients to Switch Treatments: Modest
- 708* Medicare Advantage Record Requests: Modest
- 709# Insurance Promotion of Preventive Care Services via Incentive-Based Programs: Modest
- 710# Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings: Minimal
- 711# Opposition to Elimination of "Incident-to" Billing for Non-Physician Practitioners: not yet determined

Minimal - less than \$1,000

Modest - between \$1,000 - \$5,000

Moderate - between \$5,000 - \$10,000