

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its June 2021 Special Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (JUN-21)

Report of Reference Committee B

David Teuscher, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

2
3 **RECOMMENDED FOR ADOPTION**

- 4
5 1. Board of Trustees Report 7 – Council on Legislation Sunset Review of 2011
6 House Policies
7 2. Resolution 213 – CMMI Payment Reform Model
8 3. Resolution 216 – Opposition to Federal Ban on SNAP Benefits for Persons
9 Convicted of Drug Related Felonies
10 4. Resolution 217– Amending H-150.962, Quality of School Lunch Program to
11 Advocate for the Expansion and Sustainability of Nutritional Assistance Programs
12 During COVID-19
13 5. Resolution 232 – Preventing Inappropriate Use of Patient Protected Medical
14 Information in the Vaccination Process
15 6. Resolution 233 – Non-Physician Title Misappropriation
16

17 **RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED**

- 18
19 7. Board of Trustees Report 14 – Pharmaceutical Advertising in Electronic Health
20 Records
21 8. Board of Trustees Report 18 – Digital Vaccine Credential Systems and Vaccine
22 Mandates in COVID-19
23 Resolution 230 – Considerations for Immunity Credentials During Pandemics and
24 Epidemics
25 9. Resolution 206 – Redefining the Definition of Harm
26 Resolution 212 – ONC's Information Blocking Regulations
27 10. Resolution 210 – Ransomware and Electronic Health Records
28 11. Resolution 215 – Exemptions to Work Requirements and Eligibility Expansions in
29 Public Assistance Programs
30 12. Resolution 226 – Interest-Based Debt Burden on Medical Students and
31 Residents
32 13. Resolution 227 – Audio-Only Telehealth for Risk Adjusted Payment Models
33 14. Resolution 228 – COVID-19 Vaccination Rollout to Emergency Departments and
34 Urgent Care Facilities
35 15. Resolution 229 – Classification and Surveillance of Maternal Mortality
36

1 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

- 2
3 16. Resolution 219 – Oppose Tracking of People who Purchase Naloxone

4
5 **RECOMMENDED FOR ADOPTION IN LIEU OF**

- 6
7 17. Resolution 201 – Ensuring Continued Enhanced Access to Healthcare via
8 Telemedicine and Telephonic Communication
9 18. Resolution 218 – Advocating for Alternatives to Immigrant Detention Centers that
10 Respect Human Dignity

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18 **Amendments**

19 If you wish to propose an amendment to an item of business, click here: [Submit New](#)
20 [Amendment](#)

21

RECOMMENDED FOR ADOPTION

- 1
2
3 (1) BOT 7 – COUNCIL ON LEGISLATION SUNSET REVIEW
4 OF 2011 HOUSE POLICIES
5

6 **RECOMMENDATION:**
7

8 **Recommendation in Board of Trustees Report 7 be**
9 **adopted and the remainder of the report be filed.**

10
11 **HOD ACTION: Board of Trustees Report 7 adopted and the**
12 **remainder of the report filed**
13

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

17
18 Your Reference Committee considered Board of Trustees Report 7 and agrees with the
19 recommendations for the policies in the Sunset Review. Your Reference Committee,
20 therefore, recommends adoption of Board of Trustees Report 7.

- 21
22 (2) RESOLUTION 213 – CMMI PAYMENT REFORM
23 MODELS
24

25 **RECOMMENDATION:**
26

27 **Resolution 213 be adopted.**
28

29 **HOD ACTION: Resolution 213 adopted**
30

31 RESOLVED, That our American Medical Association continue to advocate against
32 mandatory CMMI demonstration projects (Directive to Take Action); and be it further
33

34 RESOLVED, That our AMA advocate that CMS seek innovative payment and care
35 delivery model ideas from physicians and groups such as medical specialty societies to
36 guide recommendation of the PTAC and work of the CMMI to propose demonstration
37 projects that are voluntary and can be appropriately tested (Directive to Take Action);
38 and be it
39

40 RESOLVED, That our AMA advocate that CMMI focus on the development of multiple
41 pilot projects in many specialties, which are voluntary and tailored to the needs of local
42 communities and the needs of different specialties. (Directive to Take Action)
43

44 Your Reference Committee heard how Resolution 213 addresses efforts to advocate
45 against mandatory Centers for Medicare & Medicaid Services (CMS) Innovation Center
46 (CMMI) demonstration projects and to further advocate for CMS to seek innovative
47 payment and care delivery models from physician groups to help guide the work of
48 CMMI as they propose voluntary demonstration projects that can be appropriately tested
49 and advocate for CMMI to focus on the development of multiple pilot projects across
50 many specialties, which are voluntary and tailored to the needs of local communities.

1 Your Reference Committee heard that this resolution is consistent with existing AMA
2 policy and advocates that CMS work with Physician-Focused Payment Model Technical
3 Advisory Committee (PTAC) to guide CMMI to develop physician-designed models that
4 could benefit Medicare and Medicaid patients. Your Reference Committee heard how
5 our AMA is actively engaged with the physician community and has worked extensively
6 with medical specialty societies, other physician groups, and Congress to support the
7 development of well-designed Alternative Payment Model (APM) proposals that are
8 consistent with the goals of the Medicare and CHIP Reauthorization Act (MACRA)
9 passed in 2015. Moreover, your Reference Committee heard how our AMA developed
10 recommendations for the new Administration to consider that address issues with the
11 implementation of APMs. Therefore, your Reference Committee recommends that
12 Resolution 213 be adopted.

13
14 (3) RESOLUTION 216 – OPPOSITION TO FEDERAL BAN
15 ON SNAP BENEFITS FOR PERSONS CONVICTED OF
16 DRUG RELATED FELONIES

17
18 **RECOMMENDATION:**

19
20 **Resolution 216 be adopted.**

21
22 **HOD ACTION: Resolution 216 adopted**

23
24 **RESOLVED**, That our American Medical Association oppose any lifetime ban on SNAP
25 benefits imposed on individuals convicted of drug-related felonies. (New HOD Policy)

26
27 Your Reference Committee heard testimony strongly in support of Resolution 216. Your
28 Reference Committee heard that under current federal law, any individual convicted of a
29 drug-related felony is not eligible for benefits under the Supplemental Nutrition
30 Assistance Program (SNAP). Your Reference Committee heard that this provision was
31 originally part of a much larger welfare-reform package passed in 1996 to deter
32 individuals from drug-related crimes and decrease use of the welfare system. Further
33 testimony was provided that successful reentry into society from the criminal justice
34 system requires being able to meet basic needs such as food and denying access to
35 basic needs programs such as SNAP makes it harder for people with drug-related felony
36 convictions to get back on their feet. Others testified that this resolution is consistent with
37 existing AMA policy supporting SNAP and supporting a public health and medical
38 approach to treating individuals with substance use disorders rather than a punitive
39 approach. Your Reference Committee also heard testimony that AMA policy opposes
40 requiring SNAP applicants or beneficiaries to disclose medical information, including
41 former drug use and treatment history, and opposes denying assistance from these
42 programs based on drug-related felony status . However, your Reference Committee
43 heard that AMA policy does not address the impact of current federal law regarding
44 criminal drug offenses and subsequent access to SNAP benefits. Further, your
45 Reference Committee heard that, in light of the substance use epidemic, which has only
46 grown worse during the COVID-19 pandemic, and the potential for serious negative
47 health and social consequences to those individuals who were convicted of drug-related
48 felonies, this resolution should be adopted. Therefore, your Reference Committee
49 recommends that Resolution 216 be adopted.

50

1 (4) RESOLUTION 217 – AMENDING H-150.962, QUALITY
2 OF SCHOOL LUNCH PROGRAM TO ADVOCATE FOR
3 THE EXPANSION AND SUSTAINABILITY OF
4 NUTRITIONAL ASSISTANCE PROGRAMS DURING
5 COVID-19
6

7 **RECOMMENDATION:**

8
9 **Resolution 217 be adopted.**

10
11 **HOD ACTION: Resolution 217 adopted**

12
13 RESOLVED, That our American Medical Association amend policy H-150.962, “Quality of
14 School Lunch Program,” by addition as follows:

15
16 **Quality of School Lunch Program H-150.962**

- 17
18 1. Our AMA recommends to the National School Lunch Program that school meals
19 be congruent with current U.S. Department of Agriculture/Department of HHS
20 Dietary Guidelines.
21 2. Our AMA opposes legislation and regulatory initiatives that reduce or eliminate
22 access to federal child nutrition programs.
23 3. Our AMA support adoption and funding of alternative nutrition and meal
24 assistance programs during a national crisis, such as a pandemic. (Modify
25 Current HOD Policy)
26

27 Your Reference Committee heard testimony in support of Resolution 217. Your
28 Reference Committee heard some testimony that highlighted the critical importance of
29 these federal nutrition programs for vulnerable populations, further amplified by the
30 disproportionate economic impact as a result of the COVID-19 public health emergency.
31 Your Reference Committee also heard that the current Administration is working to
32 strengthen and expand these nutritional assistance programs with actions such as
33 requiring the U.S. Department of Agriculture to continue reimbursing schools and
34 childcare centers for free meals to all students regardless of their income through the
35 2021-22 school year. Your Reference Committee heard testimony that questioned
36 whether such additions were necessary to meet the goals of this resolution or if this was
37 sufficiently covered by current policy. Your Reference Committee heard that the asks of
38 this resolution were in line with our AMA’s larger goal of addressing social determinants
39 of health and combatting inequities faced by marginalized and minoritized communities.
40 Your Reference Committee heard that the proposed amendment to AMA Policy H-
41 150.962 by this resolution would address a gap in policy. Accordingly, your Reference
42 Committee recommends that Resolution 217 be adopted.
43

1 (5) RESOLUTION 232 – PREVENTING INAPPROPRIATE
2 USE OF PATIENT PROTECTED MEDICAL
3 INFORMATION IN THE VACCINATION PROCESS
4

5 **RECOMMENDATION:**

6
7 **Resolution 232 be adopted.**

8
9 **RESOLVED, That our AMA oppose the sale or transfer of**
10 **medical history data and contact information accumulated**
11 **through the scheduling or provision of government-funded**
12 **vaccinations to third parties for use in marketing or**
13 **advertising (New HOD Policy).**

14
15 **HOD ACTION: Resolution 232 adopted as amended**

16
17 RESOLVED, That our American Medical Association advocate to prohibit the use of
18 patient/customer information collected by retail pharmacies for COVID-19 vaccination
19 scheduling and/or the vaccine administration process for commercial marketing or future
20 patient recruiting purposes, especially any targeting based on medical history or
21 conditions (Directive to Take Action); and be it further
22

23 RESOLVED, That our AMA oppose the sale of medical history data and contact
24 information accumulated through the scheduling or provision of government-funded
25 vaccinations to third parties for use in marketing or advertising (New HOD Policy).
26

27 Your Reference Committee heard overwhelming testimony in support of Resolution 232.
28 Your Reference Committee heard testimony that our AMA has been actively advocating
29 to ensure that as health information is shared—particularly outside of the health care
30 system—patients have meaningful controls over and a clear understanding of how their
31 data is being used and with whom it is being shared; and that above all, patients feel
32 confident that their health information will remain private. Your Reference Committee
33 heard testimony that our AMA has been vocal in discussions with current and previous
34 Administration officials on proposed rules, regulations, and guidance documents to
35 ensure that patient privacy is at the forefront of any federal policy decisions. Therefore,
36 your Reference Committee recommends that Resolution 232 be adopted.
37

38 (6) **RESOLUTION 233 – NON-PHYSICIAN TITLE**
39 **MISAPPROPRIATION**

40
41 **RECOMMENDATION:**

42
43 **Resolution 233 be adopted.**

44
45 **HOD ACTION: Resolution 233 adopted**

46
47 RESOLVED, That our American Medical Association actively oppose the American
48 Academy of Physician Assistants' (AAPA's) recent move to change the official title of the
49 profession from "Physician Assistant" to "Physician Associate" (Directive to Take Action);
50 and be it further

1
2 RESOLVED, That our AMA actively advocate that the stand-alone title “Physician” be
3 used only to refer to doctors of allopathic medicine (MDs) and doctors of osteopathic
4 medicine (DOs), and not be used in ways that have the potential to mislead patients
5 about the level of training and credentials of non-physician health care workers.
6 (Directive to Take Action)

7
8 Your Reference Committee heard extensive and near unanimous testimony in strong
9 support of Resolution 233. Your Reference Committee heard multiple examples of how
10 Resolution 233 directly aligns with our AMA’s statement issued on July 3, 2021 opposing
11 the AAPA’s recent title change and our extensive policy supporting strong truth in
12 advertising laws. Your Reference Committee also heard of the importance of limiting the
13 title “physician” to MDs and DOs. Additionally, your Reference Committee heard that
14 Resolution 233 aligns with our ongoing commitment to opposing inappropriate
15 expansions of scope of practice and supporting our Truth in Advertising campaign.
16 Therefore, your Reference Committee recommends that Resolution 233 be adopted.
17

1 **RECOMMENDED FOR ADOPTION AS AMENDED OR**
2 **SUBSTITUTED**

- 3
4 (7) BOT 14 – PHARMACEUTICAL ADVERTISING IN
5 ELECTRONIC HEALTH RECORD SYSTEMS

6
7 **RECOMMENDATION A:**

8
9 **Recommendation in Board of Trustees Report 14 be**
10 **amended by addition** of a fourth and fifth clause to
11 **read as follows:**

12
13 **Our AMA: (1) opposes direct-to-prescriber pharmaceutical and promotional**
14 **content in electronic health records (EHR); and (2) opposes direct-to-**
15 **prescriber pharmaceutical and promotional content in medical reference**
16 **and e-prescribing software, unless such content complies with all**
17 **provisions in Direct-to-Consumer Advertising (DTCA) of Prescription Drugs**
18 **and Implantable Devices (H-105.988); and (3) encourages the federal**
19 **government to study of the effects of direct-to physician prescriber**
20 **advertising at the point of care, including advertising in Electronic Health**
21 **Record Systems (EHRs), on physician prescribing, patient safety, data**
22 **privacy, health care costs, and EHR access for small physician practices;**
23 **and (2) will study the prevalence and ethics of direct-to-physician**
24 **advertising at the point of care, including advertising in EHRs. and (4)**
25 **opposes the preferential placement of brand name medications in e-**
26 **prescription search results or listings; and (5) will encourage e-prescribing**
27 **and EHR companies to ensure that the generic medication name will**
28 **appear first in e-prescription search results and listings.**

29
30 **RECOMMENDATION B:**

31
32 **Recommendation in Board of Trustees Report 14 be**
33 **adopted as amended** and the remainder of the report
34 **be filed.**

35
36 **HOD ACTION: Board of Trustees Report 14 adopted as**
37 **amended and the remainder of the report filed**

38
39 The Board of Trustees recommends that Policy D-478.961 be amended as follows and
40 the remainder of the report be filed:

41
42 Our AMA: (1) opposes direct-to-prescriber pharmaceutical and promotional content in
43 electronic health records (EHR); and (2) opposes direct-to-prescriber pharmaceutical
44 and promotional content in medical reference and e-prescribing software, unless such
45 content complies with all provisions in Direct-to-Consumer Advertising (DTCA) of
46 Prescription Drugs and Implantable Devices (H-105.988); and (3) encourages the
47 federal government to study of the effects of direct-to physician prescriber advertising at
48 the point of care, including advertising in Electronic Health Record Systems (EHRs), on
49 physician prescribing, patient safety, data privacy, health care costs, and EHR access

1 for small physician practices; and (2) will study the prevalence and ethics of direct-to-
2 physician advertising at the point of care, including advertising in EHRs.

3
4 Your Reference Committee heard overwhelming support for BOT Report 14. Your
5 Reference Committee heard testimony that pharmaceutical companies have a long
6 history of marketing to physicians in the clinical setting and that in recent years access to
7 physicians has become more challenging for these companies. Your Reference
8 Committee also heard testimony that nearly half of physicians restrict visits from
9 pharmaceutical sales representatives leading to increased spending on advertising in
10 digital channels such as search engines and social media platforms in order to reach
11 physicians. Additionally, your Reference Committee heard significant concerns from
12 several delegations that EHR systems have become an opportunity for abuse by
13 pharmaceutical companies to directly provide information about prescription drugs to
14 prescribers, which raises significant patient safety concerns and jeopardizes the integrity
15 of patient care. Your Reference Committee was presented with compelling testimony
16 surrounding the use of the preferential placement of name brand drugs over generic
17 medications when utilizing the search action of an EHR as a more subtle form of
18 preferential advertising intended to influence the prescribing decisions of physicians.
19 Your Reference Committee heard that an amendment was needed to directly address
20 inappropriate influence of the relative placement of medication listings in E-Prescription
21 tools. Your Reference Committee was offered an amendment that would address this
22 issue of bias within the EHR E-prescribing tool which was favorably received by several
23 delegations. Your Reference Committee is recommending adoption of this amendment
24 with additional language to apply to e-prescription search results and listings. Therefore,
25 your Reference Committee recommends that BOT Report 14 be adopted as amended
26 and the remainder of the report filed.

- 27
28 (8) BOT 18 – DIGITAL VACCINE CREDENTIAL SYSTEMS
29 AND VACCINE MANDATES IN COVID-19
30 RESOLUTION 230 – CONSIDERATIONS FOR IMMUNITY
31 CREDENTIALS DURING PANDEMICS AND EPIDEMICS
32

33 **RECOMMENDATION A:**

34
35 **Recommendations in Board of Trustees Report 18 be**
36 **amended by addition of a fourth recommendation to**
37 **read as follows:**

- 38
39 4. **Recommends that vaccination credentials not be provided on the**
40 **basis of natural immunity or prior SARS-CoV-2 infection.**

41
42 **RECOMMENDATION B:**

43
44 **Recommendations in Board of Trustees Report 18 be**
45 **adopted as amended in lieu of Resolution 230 and the**
46 **remainder of the report be filed.**
47

HOD ACTION: Board of Trustees Report 18 adopted as amended in lieu of Resolution 230 and the remainder of the report filed. Amendment B3 as amended referred for decision

Amendment B3 as amended:

Recommends that vaccine credentials are not used to prevent immigration or voluntary repatriation, that vaccines be offered upon arrival in the US, and that vaccine mandates are uniformly applied regardless of citizenship.

Board of Trustees Report 18

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

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

1. Encourages the development of clear, strong, universal, and enforceable federal guidelines for the design and deployment of digital vaccination credentialing services (DVCS), and that before decisions are taken to implement use of vaccine credentials
 - a. vaccine is widely accessible;
 - b. equity-centered privacy protections are in place to safeguard data collected from individuals;
 - c. provisions are in place to ensure that vaccine credentials do not exacerbate inequities; and
 - d. credentials address the situation of individuals for whom vaccine is medically contraindicated (New HOD Policy)
2. Recommends that decisions to mandate COVID-19 vaccination be made only:
 - a. After a vaccine has received full approval from the U.S. Food and Drug Administration through a Biological Licenses Application;
 - b. In keeping with recommendations of the Advisory Committee on Immunization Practices for use in the population subject to the mandate as approved by the Director of the Centers for Disease Control and Prevention;
 - c. When individuals subject to the mandate have been given meaningful opportunity to voluntarily accept vaccination; and
 - d. Implementation of the mandate minimizes the potential to exacerbate inequities or adversely affect already marginalized or minoritized populations. (New HOD Policy)
3. Encourages the use of well-designed education and outreach efforts to promote vaccination to protect both public health and public trust. (New HOD Policy)

Resolution 230

RESOLVED, That our AMA:

- (1) oppose the implementation of natural immunity credentials, which give an individual differential privilege on the basis of natural immunity after non-vaccine exposure status to a pathogen, and

1 (2) caution that any implementation of vaccine-induced immunity credentials, which give
2 an individual differential privilege on the basis of acquired immunity after receiving a
3 vaccine, must strongly consider potential consequences on social inequity, including, but
4 not limited to,

- 5 i. continued marginalization of communities historically harmed or ignored by
6 the healthcare system,
- 7 ii. isolation of populations who may be ineligible for or unable to access vaccines,
- 8 iii. barriers preventing immigration or travel from countries with low access to
9 vaccines and the need to offer a vaccine upon arrival to anyone entering the US
10 from another country, and
- 11 iv. privacy of and accessibility to any systems used to implement vaccine-induced
12 immunity passports

13
14 Your Reference Committee heard overwhelming testimony in support of BOT Report 18
15 and mixed testimony regarding Resolution 230. Your Reference Committee heard
16 testimony that BOT 18 provides a cautionary analysis of two widely popular approaches
17 for responding to the ongoing COVID-19 pandemic. Your Reference Committee heard
18 that both vaccine credentials and mandatory vaccination strategies serve compelling
19 public interests: protecting the health of the community while allowing individuals
20 expanded opportunities for social and economic interaction. Your Reference Committee
21 heard testimony that both strategies also pose ethical and practical challenges, notably
22 to confidentiality and autonomy, and have the potential to adversely and
23 disproportionately affect members of marginalized and minoritized communities. Your
24 Reference Committee heard testimony that Resolution 230 addresses the same issues
25 as BOT 18 and includes a recommendation about natural immunity credentials that
26 should be added as a fourth recommendation in BOT 18 to enhance our AMA's
27 policy. Therefore, your Reference Committee recommends that BOT 18 be amended by
28 addition of a fourth recommendation that addresses the goal of Resolution 230 with
29 regards to natural immunity. Your Reference Committee further recommends that BOT
30 18 as amended be adopted in lieu of Resolution 230 and the remainder of the report be
31 adopted and filed.

- 32
33 (9) RESOLUTION 206 – REDEFINING THE DEFINITION OF
34 HARM
35 RESOLUTION 212 – ONC'S INFORMATION BLOCKING
36 REGULATIONS

37
38 **RECOMMENDATION A:**

39
40 **Resolution 206 be amended by addition and deletion**
41 **to read as follows:**

42
43 **RESOLVED, That our American Medical Association advocate to the Office**
44 **of Civil Rights Office for Civil Rights to revise the definition of harm to**
45 **include mental and emotional distress. Such a revision would allow**
46 **additional flexibility for clinicians under the Preventing Harm Exception,**
47 **based on their professional judgement, to withhold sensitive information**
48 **they believe could cause physical, mental or emotional harm to the patient**
49 **(Directive to Take Action); and be it further**
50

1 **RESOLVED, that our AMA advocate that the ~~Office of Civil Rights~~ Office for**
2 **Civil Rights assemble a commission of medical professionals to help the**
3 **office review the definition of harm and provide scientific evidence**
4 **demonstrating that mental and emotional health is intertwined with**
5 **physical health.**

6
7 **RESOLVED, Our AMA continue to urge the Department of Health and**
8 **Human Services (HHS)'s Office of the National Coordinator for Health**
9 **Information Technology (ONC) and its Office of Inspector General (OIG) to**
10 **leverage their enforcement discretion that would afford ~~small and medium-~~**
11 **~~sized~~ medical practices additional compliance flexibilities ~~given their lack~~**
12 **of resources.**

13
14 **RESOLVED, That our AMA urge the ONC to earnestly consult with relevant**
15 **stakeholders about unintended or unforeseen consequences that may**
16 **arise from the information blocking regulations.**

17
18 **RECOMMENDATION B:**

19
20 **Resolution 206 be adopted as amended in lieu of**
21 **Resolution 212.**

22
23 **HOD ACTION: Resolution 206 adopted as amended in lieu**
24 **of Resolution 212**

25
26 **Resolution 206**

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

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

38
39 **Resolution 212**

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

- 44
45 a. **Urge the ONC to strike the right balance between the demands and distress**
46 **caused by the COVID-19 public health emergency (PHE) and its interoperability**
47 **rule objectives.**
48 b. **Urge the ONC to earnestly consult with relevant stakeholders about unintended**
49 **or unforeseen consequences that may arise from the information blocking**
50 **regulations.**

- 1 c. Urge the ONC, through an interim final rule moratorium, to delay the current
2 applicability date of information blocking provisions until 12 months after the PHE
3 is officially declared over, affording small and medium-sized medical practices
4 time to recover and prepare.
- 5 d. Urge the Department of Health and Human Services (HHS)'s ONC and their OIG
6 to propose future enforcement discretion that would afford small and medium-
7 sized medical practices further compliance flexibilities given their lack of
8 resources.
- 9 e. Call on the HHS's ONC and OIG in future enforcement rulemaking to propose
10 corrective action and further technical guidance rather than imposing fines or
11 penalties.
- 12 f. Urge the ONC to broaden and relax its Patient Harm Exception through
13 subregulatory revisions that would include patients' emotional and mental
14 distress to the current and narrow definition of this exception.
- 15 g. Call on the ONC to develop and offer more meaningful educational guidance,
16 practical resources, and technical assistance to physician practices to help them
17 meet their compliance efforts, patient care obligations and documentation
18 requirements. (Directive to Take Action)

19
20 Your Reference Committee heard testimony primarily in favor of adopting Resolution
21 206 and mixed testimony regarding Resolution 212. Your Reference Committee heard
22 that, while HIPAA requires covered entities to provide access to personal health
23 information (PHI) to individuals and their personal representatives, disclosures to other
24 parties are permissive, not required. Your Reference Committee also heard testimony
25 that new information blocking regulations from the Office of the National Coordinator for
26 Health Information Technology (ONC) require physicians to make available a variety of
27 medical information (e.g., lab tests, clinical notes, medications, etc.) to not only the
28 individual/personal representative, but also any other entity or individual requesting
29 information for or on behalf of the patient. Your Reference Committee also heard
30 testimony that while patients accessing their medical information is an important part of
31 patient-centered care and our AMA strongly supports patient access and engagement,
32 there are a variety of ethical, professional, and practical concerns with automatically and
33 immediately releasing all reports and office notes. Your Reference Committee also heard
34 testimony that the ONC has created eight exceptions outlining reasonable and necessary
35 practices physicians may take to withhold information, including the Harm
36 Exception which allows a physician to withhold the release of information only in cases of
37 anticipated physical harm to the patient or another individual. Your Reference Committee
38 heard testimony that this guidance is based on an interpretation by the Office for Civil
39 Rights that "harm" is defined only as physical, not mental or emotional. Your Reference
40 Committee also heard testimony that, under current regulation, physicians must still
41 release health information even when, in their professional judgement, they believe that
42 doing so could emotionally or psychologically harm their patient. Your Reference
43 Committee heard testimony that Resolution 206 needs a minor technical amendment to
44 change the "Office of Civil Rights" to the "Office for Civil Rights." Your Reference
45 Committee also heard testimony that the goal of Resolution 212 can be captured with
46 the addition of a third Resolved to Resolution 206 that urges ONC and the HHS OIG to
47 leverage enforcement discretion that would afford small and medium-sized medical
48 practices additional compliance flexibilities. Therefore, your Reference Committee
49 recommends that Resolution 206 be adopted, as amended, in lieu of Resolution 212.

1 (10) RESOLUTION 210 – RANSOMWARE AND ELECTRONIC
2 HEALTH RECORDS

3
4 **RECOMMENDATION A:**

5
6 **Resolution 210 be amended by addition and deletion**
7 **to read as follows:**

8
9 **RESOLVED, That our American Medical Association adopt policy**
10 **acknowledging that healthcare data interruptions are especially harmful**
11 **due to potential physical harm to patients and calling for prosecution to the**
12 **fullest extent of the law for perpetrators of ransomware and any other**
13 **malware on independent physicians and their practices, healthcare**
14 **organizations, or other medical entities involved in providing direct and**
15 **indirect care to patients (New HOD Policy); and be it further**

16
17 **RESOLVED, That our AMA advocate for ~~seek to introduce~~ federal**
18 **legislation which provides for the prosecution of perpetrators of**
19 **ransomware and any other malware on any and all healthcare entities,**
20 **involved in direct and indirect patient care, to the fullest extent of the law.**
21 **(Directive to Take Action)**

22
23 **RESOLVED, That our AMA encourage health care facilities and integrated**
24 **networks that are under threat of ransomware attacks to upgrade their**
25 **cybersecurity and to back up data in a robust and timely fashion.**

26
27 **RESOLVED, That our AMA advocate that the security of protected**
28 **healthcare information be considered as an integral part of national**
29 **cybersecurity protection, and be it further**

30
31 **RESOLVED, That our AMA seek inclusion of federal cybersecurity**
32 **resources allocated to physician practices, hospitals, and health care**
33 **entities sufficient to protect the security of the patients they serve, as part**
34 **of infrastructure legislation.**

35
36 **RECOMMENDATION B:**

37
38 **Resolution 210 be adopted as amended.**

39
40 **HOD ACTION: Resolution 210 adopted as amended**

41
42 **RESOLVED, That our American Medical Association adopt policy acknowledging that**
43 **healthcare data interruptions are especially harmful due to potential physical harm to**
44 **patients and calling for prosecution to the fullest extent of the law for perpetrators of**
45 **ransomware and any other malware on independent physicians and their practices,**
46 **healthcare organizations, or other medical entities involved in providing direct and**
47 **indirect care to patients (New HOD Policy); and be it further**

48
49 **RESOLVED, That our AMA seek to introduce federal legislation which provides for the**
50 **prosecution of perpetrators of ransomware and any other malware on any and all**

1 healthcare entities, involved in direct and indirect patient care, to the fullest extent of the
2 law. (Directive to Take Action)

3
4 Your Reference Committee heard testimony in support of Resolution 210. Your
5 Reference Committee heard testimony that our AMA has actively been working on
6 cybersecurity preparedness, education, and resilience for many years. Your Reference
7 Committee heard testimony that our AMA has led the field in framing cybersecurity as a
8 patient safety issue, and as a result, is better situated to monitor and support efforts to
9 promote these concepts in federal legislative and regulatory settings than it is to
10 introduce legislation contemplating possible criminal and civil prosecutions and
11 accordingly your Reference Committee heard an amendment was needed to support
12 this work. Your Reference Committee heard an amendment concerning the importance
13 of ensuring that health care facilities and integrated networks upgrade their cybersecurity
14 and back up data in a robust and timely fashion to guarantee that patient data is
15 adequately protected. Your Reference Committee heard multiple testimonies in support
16 of the amendment on upgrading security and heard how this fills a gap in current AMA
17 Policy. Therefore, your Reference Committee recommends that Resolution 210 be
18 adopted as amended.

- 19
20 (11) RESOLUTION 215 – EXEMPTIONS TO WORK
21 REQUIREMENTS AND ELIGIBILITY EXPANSIONS IN
22 PUBLIC ASSISTANCE PROGRAMS

23
24 **RECOMMENDATION A:**

25
26 **The first Resolve of Resolution 215 be amended by**
27 **addition and deletion to read as follows:**

28
29 **RESOLVED, That our American Medical Association support ~~reduction and~~**
30 **elimination of work requirements ~~applied to the~~ used as eligibility criteria in**
31 **public assistance programs, including the Supplemental Nutrition**
32 **Assistance Program (SNAP) and the Temporary Assistance for Needy**
33 **Families Program (TANF) (New HOD Policy); and be it further**

34
35 **RECOMMENDATION B:**

36
37 **Resolution 215 be amended by the addition of a third**
38 **Resolve.**

39
40 **RESOLVED, That our AMA work with state medical societies to encourage**
41 **states to establish express lane eligibility (ELE) programs that use**
42 **eligibility data from the maximum number of Express Lane Agencies**
43 **(ELAs) feasible, which include SNAP, TANF, and other programs as**
44 **described by the Centers for Medicare & Medicaid Services, to facilitate**
45 **enrollment in Medicaid and the Children’s Health Insurance Program**
46 **(CHIP). (New HOD Policy)**
47

1 **RECOMMENDATION C:**

2
3 **Resolution 215 be adopted as amended.**

4
5 **HOD ACTION: Resolution 215 adopted as amended**

6
7 RESOLVED, That our American Medical Association support reduction and elimination
8 of work requirements applied to the Supplemental Nutrition Assistance Program (SNAP)
9 and the Temporary Assistance for Needy Families Program (TANF) (New HOD Policy);
10 and be it further

11
12 RESOLVED, That our AMA support states' ability to expand eligibility for public
13 assistance programs beyond federal standards, including automatically qualifying
14 individuals for a public assistance program based on their eligibility for another program.
15 (New HOD Policy)

16
17 Your Reference Committee heard overwhelmingly positive testimony in support of
18 Resolution 215 and the amendment offered on Resolution 215. Your Reference
19 Committee heard that the economic crisis caused by the pandemic has highlighted the
20 need for a strong safety net programs, including SNAP and TANF. Your Reference
21 Committee heard that existing AMA policy opposes work requirements in the Medicaid
22 program and that adoption of Resolution 215 would build on policy that is supportive of
23 assistance programs for low-income individuals and families. Your Reference Committee
24 heard supporting testimony for an additional resolved that would call on our AMA to work
25 with state medical societies to encourage states to establish ELE programs that use
26 eligibility data to facilitate enrollment in Medicaid and CHIP. Therefore, your Reference
27 Committee recommends adoption of Resolution 215 as amended.

28
29 (12) RESOLUTION 226 – INTEREST-BASED DEBT BURDEN
30 ON MEDICAL STUDENTS AND RESIDENTS

31
32 **RECOMMENDATION A:**

33
34 **Resolution 226 be amended by addition and deletion**
35 **to read as follows:**

36
37 **RESOLVED: That our AMA strongly advocate for the passage of legislation**
38 **to allow ~~borrowers~~ medical students, residents and fellows who have**
39 **education loans to qualify for interest-free deferment on their student loans**
40 **while serving in a medical ~~or dental~~ internship, residency, or fellowship**
41 **program, as well as permitting the conversion of currently unsubsidized**
42 **Stafford and Graduate Plus loans to interest free status for the duration of**
43 **undergraduate and graduate medical education. (Directive to Take Action)**

44
45 **RECOMMENDATION B:**

46
47 **Resolution 226 be adopted as amended.**

48
49 **HOD ACTION: Resolution 226 adopted as amended**

50

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

7
8 Your Reference Committee heard overwhelming testimony in support of Resolution 226.
9 Your Reference Committee heard that although our AMA has extensive policy
10 surrounding student loans and mitigating the harm of these loans on physicians and
11 medical students, Resolution 226 fills a gap in current policy that would specify the
12 deferment of student loan interest accrual during internship, residency, or fellowship
13 programs, as well as permitting the conversion of currently unsubsidized Stafford and
14 Graduate Plus loans to interest free status for the duration of undergraduate and
15 graduate medical education. Your Reference Committee heard that this proposed policy
16 change falls in line with our current advocacy efforts, including our AMA's support of the
17 "Resident Education Deferred Interest Act" introduced during the 116th Congress. Your
18 Reference Committee also heard compelling testimony from our members regarding
19 their personal experiences with struggling to pay off their student loan debt, which was
20 compounded by large amounts of interest. Your Reference Committee also heard
21 testimony from multiple delegations that the language of this resolution could be
22 specified even further to support medical students, residents, and fellows who have
23 education loans during their undergraduate and graduate medical education. As such,
24 your Reference Committee recommends that Resolution 226 be adopted as amended.

25
26 (13) RESOLUTION 227– AUDIO-ONLY TELEHEALTH FOR
27 RISK ADJUSTED PAYMENT MODELS

28
29 **RECOMMENDATION A:**

30
31 **Resolution 227 be amended by addition and deletion**
32 **to read as follows:**

33
34 **RESOLVED, That our American Medical Association advocate that**
35 **diagnoses coded for audio-only telehealth encounters diagnoses be**
36 **included in risk adjusted payment models.**

37
38 **RECOMMENDATION B:**

39
40 **Resolution 227 be amended by addition of a second**
41 **Resolve to read as follows:**

42
43 **RESOLVED, Our AMA advocate for coverage and payment of audio-only**
44 **services in appropriate circumstances to ensure equitable coverage for**
45 **patients who need access to telecommunication services but who do not**
46 **have access to two-way audio-visual technology. (Directive to Take Action)**

1
2 **RECOMMENDATION C:**

3
4 **Resolution 227 be adopted as amended.**

5
6 **HOD ACTION: Resolution 227 adopted as amended**

7
8 **RESOLVED**, That our AMA advocate that audio-only telehealth encounter diagnoses be
9 included in risk adjusted payment models. (Directive to Take Action)

10
11 Your Reference Committee heard testimony in support of Resolution 227. Your
12 Reference Committee heard testimony from multiple delegations expressing that the
13 expanded use of audio-visual telehealth services during the pandemic has made it clear
14 that requiring the use of a video connection inappropriately limits the number of patients
15 who can benefit from telecommunications-supported services. Your Reference
16 Committee heard testimony on the equity implications related to differences in the
17 accessibility of telehealth resources for patients, particularly lower-income patients and
18 those residing in rural and other areas with limited broadband access. Your Reference
19 Committee heard extensive testimony that physicians should continue to be able to
20 deliver appropriate services by telephone, including E/M services, to patients who need
21 a telecommunications-based service but who do not have access to a video connection
22 or cannot successfully use one. Your Reference Committee also heard testimony that
23 the resolution would benefit from an amendment addressing coverage and payment for
24 audio-only services in appropriate circumstances in risk-adjusted plans like Medicare
25 Advantage and that this amendment is critical to ensuring equity is prioritized in policy
26 surrounding the development and delivery of telehealth services. Your Reference
27 Committee was proffered an amendment that would address the concerns surrounding
28 coverage and payment for audio-only services in appropriate care settings which would
29 further extend care to all patients regardless of income status. Therefore, your
30 Reference Committee recommends that Resolution 227 be adopted as amended.

31
32 (14) RESOLUTION 228 – COVID-19 VACCINATION
33 ROLLOUT TO EMERGENCY DEPARTMENTS AND
34 URGENT CARE FACILITIES

35
36 **RECOMMENDATION A:**

37
38 **Resolution 228 be amended by addition and deletion**
39 **to read as follows:**

40
41 ~~**RESOLVED**, That our AMA acknowledge that our nation's COVID-19~~
42 ~~**vaccine rollout is not yet optimized, and we have a duty to vaccinate as**~~
43 ~~**many people in an effective manner; and be it further**~~

44
45 **RESOLVED**, That our AMA work with other relevant organizations and
46 stakeholders to lobby the current Administration for the distribution of
47 COVID-19 vaccinations to our nation's emergency departments and urgent
48 care facilities during the COVID-19 public health emergency; ~~and be it~~
49 ~~further~~

50

1 ~~RESOLVED, That our AMA advocate for additional funding to be directed~~
2 ~~towards increasing COVID-19 vaccine ambassador programs in emergency~~
3 ~~departments and urgent care facilities.~~

4
5 **RECOMMENDATION B:**

6
7 **Resolution 228 be adopted as amended.**

8
9 **RECOMMENDATION C:**

10
11 **AMA Policies D-440.921 and H-440.875 be reaffirmed.**

12
13 **HOD ACTION: Resolution 228 adopted as amended**
14 **Policies D-440.921 and H-440.875 reaffirmed**

15
16 RESOLVED, That our AMA acknowledge that our nation's COVID-19 vaccine rollout is
17 not yet optimized, and we have a duty to vaccinate as many people in an effective
18 manner; and be it
19 further

20
21 RESOLVED, That our AMA work with other relevant organizations and stakeholders to
22 lobby the current Administration for the distribution of COVID-19 vaccinations to our
23 nation's emergency departments and urgent care facilities; and be it further

24
25 RESOLVED, That our AMA advocate for additional funding to be directed towards
26 increasing COVID-19 vaccine ambassador programs in emergency departments and
27 urgent care facilities.

28
29 Your Reference Committee heard mixed testimony on Resolution 228. Your Reference
30 Committee was presented with concerns regarding the ability of emergency departments
31 and urgent care centers to acquire COVID-19 vaccine doses or otherwise participate in
32 vaccination campaigns throughout the COVID-19 public health emergency. However,
33 your Reference Committee also heard testimony that our AMA already strongly
34 advocates for the inclusion of physicians in all COVID-19 vaccination campaigns and for
35 COVID-19 vaccinations to be available in all circumstances. Additionally, your Reference
36 Committee heard testimony that our AMA has already adopted timely and robust policy
37 regarding COVID-19 vaccine efforts, most recently at the November 2020 special
38 meeting. Therefore, your Reference Committee recommends adoption of Resolution 228
39 as amended. Your Reference Committee also recommends reaffirmation of existing
40 policies D-440.921 and H-440.875 in lieu of resolved one and three.

41
42 **An Urgent Initiative to Support COVID-19 Vaccination Programs D-440.921**

43
44 Our AMA will institute a program to promote the integrity of a COVID-19
45 vaccination program by: (1) educating physicians on speaking with patients about
46 COVID-19 vaccination, bearing in mind the historical context of “experimentation”
47 with vaccines and other medication in communities of color, and providing
48 physicians with culturally appropriate patient education materials; (2) educating
49 the public about the safety and efficacy of COVID-19 vaccines, by countering
50 misinformation and building public confidence; (3) forming a coalition of health

1 care and public health organizations inclusive of those respected in communities
2 of color committed to developing and implementing a joint public education
3 program promoting the facts about, promoting the need for, and encouraging the
4 acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of
5 COVID-19 vaccines to ensure that the evidence continues to support safe and
6 effective use of vaccines among recommended populations.

7
8 **Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875**
9

10 1. It is AMA policy that all persons, regardless of economic and insurance status,
11 receive all Advisory Committee on Immunization Practices (ACIP)-recommended
12 vaccines as soon as possible following publication of these recommendations in
13 the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality
14 Weekly Report (MMWR).

15
16 2. Our AMA will continue to work with the federal government, Congress, and
17 other stakeholders to improve liability protection for vaccine manufacturers and
18 health care professionals who provide immunization services and to examine and
19 improve compensation mechanisms for patients who were legitimately injured by
20 a vaccine.

21
22 3. Our AMA will continue to work with the federal government, Congress, and
23 other appropriate stakeholders to enhance public opinion of vaccines and to
24 monitor and ensure the continued safety of existing and newly approved
25 vaccines (including providing adequate resources for post-approval surveillance)
26 so as to maintain and improve public confidence in the safety of vaccines.

27
28 4. Our AMA will work with appropriate stakeholders, including vaccine
29 manufacturers, vaccine distributors, the federal government, medical specialty
30 societies, and third party payers, to guarantee a robust vaccine delivery
31 infrastructure (including but not limited to, the research and development of new
32 vaccines, the ability to track the real-time supply status of ACIP-recommended
33 vaccines, and the timely distribution of ACIP-recommended vaccines to
34 providers).

35
36 5. Our AMA will work with appropriate federal and state agencies and private
37 sector entities to ensure that state Medicaid agencies and private insurance
38 plans pay health care professionals at least the approved Relative Value Unit
39 (RVU) administration Medicare rates for payment when they administer ACIP-
40 recommended vaccines.

41
42 6. Our AMA will work with the Centers for Medicare and Medicaid Services
43 (CMS) to address barriers associated with Medicare recipients receiving live
44 zoster vaccine and the routine boosters Td and Tdap in physicians' offices.

45
46 7. Our AMA will work through appropriate state entities to ensure all health
47 insurance plans rapidly include newly ACIP-recommended vaccines in their list of
48 covered benefits, and to pay health care professionals fairly for the purchase and
49 administration of ACIP-recommended vaccines.
50

1 8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular
2 Pertussis) under Medicare Part B as a national public health measure to help
3 prevent the spread of Pertussis.
4

5 9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's
6 satisfaction regarding the tetanus vaccine, our AMA will aggressively petition
7 CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual
8 Medicare Wellness visits, and other clinically appropriate encounters, as
9 additional "triggering event codes" (using the AT or another modifier) that allow
10 for coverage and payment of vaccines to Medicare recipients.
11

12 10. Our AMA will aggressively petition CMS to include coverage and payment for
13 any vaccinations administered to Medicare patients that are recommended by
14 the ACIP, the US Preventive Services Task Force (USPSTF), or based on
15 prevailing preventive clinical health guidelines.
16

17 (15) RESOLUTION 229 – CLASSIFICATION AND
18 SURVEILLANCE OF MATERNAL MORTALITY
19

20 **RECOMMENDATION A:**

21
22 **Resolution 229 be amended by addition and deletion**
23 **to read as follows:**
24

25 ~~**RESOLVED, That our AMA advocate for an annual release of the national**~~
26 ~~**maternal mortality rate in the United States; and be it further**~~
27

28 ~~**RESOLVED, That our AMA will collaborate with relevant stakeholders to**~~
29 ~~**advocate for a reliable, accurate, and standardized definition of maternal**~~
30 ~~**mortality that will be implemented across states for tracking data on**~~
31 ~~**maternal mortality; and be it further**~~
32

33 **RESOLVED, That our AMA encourage research efforts to characterize the**
34 **health needs for pregnant inmates, including efforts that utilize data**
35 **acquisition directly from pregnant inmates while ensuring appropriate**
36 **nondiscrimination and privacy safeguards; and be it further**
37

38 **RESOLVED, That our AMA support legislation requiring all correctional**
39 **facilities, including those that are privately-owned, to collect and publicly**
40 **report pregnancy-related healthcare statistics with transparency in the data**
41 **collection process while ensuring appropriate nondiscrimination and**
42 **privacy safeguards.**
43

44 **RECOMMENDATION B:**

45
46 **Resolution 229 be adopted as amended.**
47
48

1 **RECOMMENDATION C:**

2
3 **AMA Policies D-420.993, H-430.986, H-315.983, and H-**
4 **60.909 be reaffirmed.**

5
6 **HOD ACTION: Resolution 229 adopted as amended.**
7 **Policies D-420.993, H-430.986, H-315.983, and H-60.909**
8 **reaffirmed**

9
10 RESOLVED, That our AMA advocate for an annual release of the national maternal
11 mortality rate in the United States; and be it further

12
13 RESOLVED, That our AMA will collaborate with relevant stakeholders to advocate for a
14 reliable, accurate, and standardized definition of maternal mortality that will be
15 implemented across states for tracking data on maternal mortality; and be it further

16
17 RESOLVED, That our AMA encourage research efforts to characterize the health needs
18 for pregnant inmates, including efforts that utilize data acquisition directly from pregnant
19 inmates; and be it further

20
21 RESOLVED, That our AMA support legislation requiring all correctional facilities,
22 including those that are privately-owned, to collect and publicly report pregnancy-related
23 healthcare statistics with transparency in the data collection process.

24
25 Your Reference Committee heard mixed testimony that while more comprehensive
26 maternal mortality and morbidity data is needed, Resolution 229 does not completely
27 achieve this goal. Your Reference Committee heard testimony that our AMA has existing
28 policy, State Maternal Mortality Review Committees H-60.909, which touches on the
29 issues related to data collection related to maternal mortality highlighted in Resolution
30 229. Additionally, your Reference Committee heard testimony that our AMA has been
31 strongly advocating for increased funding and technical assistance by the federal
32 government so that all states and territories may develop their own State Maternal
33 Mortality Review Committees (MMRCs). Your Reference Committee was presented with
34 testimony highlighting that our AMA's Council on Medical Service and the Council on
35 Science and Public Health are currently drafting a joint report, in the first in an
36 anticipated series of reports, focused on improving maternal health. Your Reference
37 Committee heard testimony that MMRCs provide more comprehensive and robust data
38 because local health care providers actually meet to discuss these deaths on a case-by-
39 case basis and do not simply use the vital statistics or death records through Pregnancy
40 Mortality Surveillance System (PMSS). Your Reference Committee heard testimony that
41 the Centers for Disease Control and Prevention (CDC) has worked to develop and utilize
42 the Maternal Mortality Review Information Application (MMRIA, or "Maria"), a data
43 system designed to facilitate MMRC functions through a common data language, and
44 that the CDC, in partnership with users from the committees and other subject matter
45 experts, developed the system, which is available to all MMRCs as an option to increase
46 access to national data. Moreover, your Reference Committee heard testimony that the
47 CDC and the National Center for Health Statistics released a report on maternal
48 mortality last year, the first of its kind since 2007.

49

1 Your Reference Committee heard testimony that while obtaining more pregnant inmate
2 data is a laudable goal for our organization, our AMA also has policy protecting the
3 privacy of such individuals from discrimination due to the use of such data by U.S.
4 Immigration and Customs Enforcement (ICE) or other agencies, and therefore any policy
5 surrounding data collection, particularly surrounding vulnerable populations, must have
6 robust privacy protections. Therefore, your Reference Committee recommends that D-
7 420.993, H-430.986, H-315.983 and H-60.909 be reaffirmed in lieu of Resolved 1 and 2
8 of Resolution 229; and that Resolved 3 and 4 be adopted as amended.

9 10 **Disparities in Maternal Mortality D-420.993**

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

23 24 **Health Care While Incarcerated H-430.986**

25
26 1. Our AMA advocates for adequate payment to health care providers, including
27 primary care and mental health, and addiction treatment professionals, to
28 encourage improved access to comprehensive physical and behavioral health
29 care services to juveniles and adults throughout the incarceration process from
30 intake to re-entry into the community.

31
32 2. Our AMA supports partnerships and information sharing between correctional
33 systems, community health systems and state insurance programs to provide
34 access to a continuum of health care services for juveniles and adults in the
35 correctional system.

36
37 3. Our AMA encourages state Medicaid agencies to accept and process
38 Medicaid applications from juveniles and adults who are incarcerated.

39
40 4. That our AMA encourage state Medicaid agencies to work with their local
41 departments of corrections, prisons, and jails to assist incarcerated juveniles and
42 adults who may not have been enrolled in Medicaid at the time of their
43 incarceration to apply and receive an eligibility determination for Medicaid.

44
45 5. Our AMA encourages states to suspend rather than terminate Medicaid
46 eligibility of juveniles and adults upon intake into the criminal justice system and
47 throughout the incarceration process, and to reinstate coverage when the
48 individual transitions back into the community.

49

1 6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services
2 (CMS), and state Medicaid agencies to provide Medicaid coverage for health
3 care, care coordination activities and linkages to care delivered to patients up to
4 30 days before the anticipated release from adult and juvenile correctional
5 facilities in order to help establish coverage effective upon release, assist with
6 transition to care in the community, and help reduce recidivism.

7
8 7. Our AMA advocates for necessary programs and staff training to address the
9 distinctive health care needs of incarcerated women and adolescent females,
10 including gynecological care and obstetrics care for pregnant and postpartum
11 women.

12 8. Our AMA will collaborate with state medical societies and federal regulators to
13 emphasize the importance of hygiene and health literacy information sessions for
14 both inmates and staff in correctional facilities.

15
16 9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon
17 release in order to accelerate access to comprehensive health care, including
18 mental health and substance abuse disorder services, and improve health
19 outcomes among this vulnerable patient population, as well as adequate funding;
20 and (b) the collaboration of correctional health workers and community health
21 care providers for those transitioning from a correctional institution to the
22 community.

23 **Patient Privacy and Confidentiality H-315.983**

24
25
26 1. Our AMA affirms the following key principles that should be consistently
27 implemented to evaluate any proposal regarding patient privacy and the
28 confidentiality of medical information: (a) That there exists a basic right of
29 patients to privacy of their medical information and records, and that this right
30 should be explicitly acknowledged; (b) That patients' privacy should be honored
31 unless waived by the patient in a meaningful way or in rare instances when
32 strong countervailing interests in public health or safety justify invasions of
33 patient privacy or breaches of confidentiality, and then only when such invasions
34 or breaches are subject to stringent safeguards enforced by appropriate
35 standards of accountability; (c) That patients' privacy should be honored in the
36 context of gathering and disclosing information for clinical research and quality
37 improvement activities, and that any necessary departures from the preferred
38 practices of obtaining patients' informed consent and of de-identifying all data be
39 strictly controlled; (d) That any information disclosed should be limited to that
40 information, portion of the medical record, or abstract necessary to fulfill the
41 immediate and specific purpose of disclosure; and (e) That the Health Insurance
42 Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for
43 protecting clinician-patient privilege, regardless of where care is received.

44
45 2. Our AMA affirms: (a) that physicians and medical students who are patients
46 are entitled to the same right to privacy and confidentiality of personal medical
47 information and medical records as other patients, (b) that when patients
48 exercise their right to keep their personal medical histories confidential, such
49 action should not be regarded as fraudulent or inappropriate concealment, and
50 (c) that physicians and medical students should not be required to report any

1 aspects of their patients' medical history to governmental agencies or other
2 entities, beyond that which would be required by law.

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

15
16 4. Whenever possible, medical records should be de-identified for purposes of
17 use in connection with utilization review, panel credentialing, quality assurance,
18 and peer review.

19
20 5. The fundamental values and duties that guide the safekeeping of medical
21 information should remain constant in this era of computerization. Whether they
22 are in computerized or paper form, it is critical that medical information be
23 accurate, secure, and free from unauthorized access and improper use.

24
25 6. Our AMA recommends that the confidentiality of data collected by race and
26 ethnicity as part of the medical record, be maintained.

27
28 7. Genetic information should be kept confidential and should not be disclosed to
29 third parties without the explicit informed consent of the tested individual.

30
31 8. When breaches of confidentiality are compelled by concerns for public health
32 and safety, those breaches must be as narrow in scope and content as possible,
33 must contain the least identifiable and sensitive information possible, and must
34 be disclosed to the fewest possible to achieve the necessary end.

35
36 9. Law enforcement agencies requesting private medical information should be
37 given access to such information only through a court order. This court order for
38 disclosure should be granted only if the law enforcement entity has shown, by
39 clear and convincing evidence, that the information sought is necessary to a
40 legitimate law enforcement inquiry; that the needs of the law enforcement
41 authority cannot be satisfied by non-identifiable health information or by any
42 other information; and that the law enforcement need for the information
43 outweighs the privacy interest of the individual to whom the information pertains.
44 These records should be subject to stringent security measures.

45
46 10. Our AMA must guard against the imposition of unduly restrictive barriers to
47 patient records that would impede or prevent access to data needed for medical
48 or public health research or quality improvement and accreditation activities.
49 Whenever possible, de-identified data should be used for these purposes. In
50 those contexts where personal identification is essential for the collation of data,

1 review of identifiable data should not take place without an institutional review
2 board (IRB) approved justification for the retention of identifiers and the consent
3 of the patient. In those cases where obtaining patient consent for disclosure is
4 impracticable, our AMA endorses the oversight and accountability provided by an
5 IRB.
6

7 11. Marketing and commercial uses of identifiable patients' medical information
8 may violate principles of informed consent and patient confidentiality. Patients
9 divulge information to their physicians only for purposes of diagnosis and
10 treatment. If other uses are to be made of the information, patients must first give
11 their uncoerced permission after being fully informed about the purpose of such
12 disclosures
13

14 12. Our AMA, in collaboration with other professional organizations, patient
15 advocacy groups and the public health community, should continue its advocacy
16 for privacy and confidentiality regulations, including: (a) The establishment of
17 rules allocating liability for disclosure of identifiable patient medical information
18 between physicians and the health plans of which they are a part, and securing
19 appropriate physicians' control over the disposition of information from their
20 patients' medical records. (b) The establishment of rules to prevent disclosure of
21 identifiable patient medical information for commercial and marketing purposes;
22 and (c) The establishment of penalties for negligent or deliberate breach of
23 confidentiality or violation of patient privacy rights.
24

25 13. Our AMA will pursue an aggressive agenda to educate patients, the public,
26 physicians and policymakers at all levels of government about concerns and
27 complexities of patient privacy and confidentiality in the variety of contexts
28 mentioned.
29

30 14. Disclosure of personally identifiable patient information to public health
31 physicians and departments is appropriate for the purpose of addressing public
32 health emergencies or to comply with laws regarding public health reporting for
33 the purpose of disease surveillance.
34

35 15. In the event of the sale or discontinuation of a medical practice, patients
36 should be notified whenever possible and asked for authorization to transfer the
37 medical record to a new physician or care provider. Only de-identified and/or
38 aggregate data should be used for "business decisions," including sales,
39 mergers, and similar business transactions when ownership or control of medical
40 records changes hands.
41

42 16. The most appropriate jurisdiction for considering physician breaches of
43 patient confidentiality is the relevant state medical practice act. Knowing and
44 intentional breaches of patient confidentiality, particularly under false pretenses,
45 for malicious harm, or for monetary gain, represents a violation of the
46 professional practice of medicine.
47

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

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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.

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.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(16) RESOLUTION 219 – OPPOSE TRACKING OF PEOPLE
WHO PURCHASE NALOXONE

RECOMMENDATION:

**That AMA Policies H-315.983, H-440.813, and H-95.932
be reaffirmed in lieu of Resolution 219.**

**RESOLVED, That our AMA oppose any policies, regulations, or laws that
require personally identifiable information associated with naloxone
prescriptions or purchases to be tracked, monitored, or utilized for non-
clinical or non-public health care purposes; and be it further**

**RESOLVED, That our AMA advocate for availability of naloxone as an over-
the-counter medication. (New HOD Policy)**

**HOD ACTION: Resolution 219 adopted as amended.
Policies H-315.983, H-440.813, and H-95.932 reaffirmed**

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

Your Reference Committee heard testimony in strong support of the intent of Resolution 219. Your Reference Committee heard testimony supportive regarding the overall need to increase access to and safeguard patient privacy and confidentiality with respect to a prescription for naloxone. Your Reference Committee agrees that an individual should not be discriminated against because his or her prescription history includes a prescription for naloxone. Your Reference Committee further agrees that naloxone should be available over-the-counter (OTC) to help increase access to naloxone.

Your Reference Committee heard that our AMA is deeply engaged in each of these issues. Your Reference Committee heard testimony that, while utilizing our current policy on safeguarding patient privacy and confidentiality (H-315.983 Patient Privacy and Confidentiality), our AMA has been able to advocate to the National Association of Insurance Commissioners that a prescription for naloxone should never be tracked or used by itself to adversely affect an individual in any line of insurance. Your Reference Committee heard that Massachusetts and Colorado are two states that have issued bulletins based on AMA advocacy, making this point clear to all insurance carriers in those states. Your Reference Committee heard that our AMA will take similar action in any other state where this becomes an issue. Your Reference Committee agrees that a naloxone prescription—by itself—is not indicative whether an individual is at risk of an opioid-related overdose.

Your Reference Committee heard that our AMA continues to advocate for comprehensive public health and data surveillance on multiple aspects of the nation's drug overdose epidemics, actions which include hosting broad, national stakeholder meetings to identify best practices, advocate for standardization, and urging states to

1 use de-identified non-fatal and fatal overdose data to identify areas where targeted
2 prevention, treatment and harm reduction resources are needed. Your Reference
3 Committee heard that current policy H-440.813, Public Health Surveillance, has been
4 utilized to advocate on issues of public health and data surveillance issues to groups
5 ranging from the National Governors Association to the National Association of
6 Attorneys General and the Pew Charitable Trusts.

7
8 Your Reference Committee heard that the position of our AMA on the accessibility of
9 naloxone over the counter, current policy H-95.932, Increasing Availability of Naloxone,
10 makes clear that “Our AMA encourages manufacturers or other qualified sponsors to
11 pursue the application process for over the counter approval of naloxone with the Food
12 and Drug Administration.” Your Reference Committee considered that our AMA has
13 supported and promoted FDA’s actions to create labeling and other information to
14 support manufacturers to submit over the counter applications.

15
16 Your Reference Committee heard testimony in support of increasing access to naloxone,
17 reducing stigma and helping save lives from overdose. Your Reference Committee
18 heard that our AMA has engaged in ongoing efforts to accomplish the intent of the
19 resolution and much more, including helping enact laws that increase access in all 50
20 states, protect patient confidentiality in prescription drug monitoring programs, remove
21 inappropriate insurance company actions concerning naloxone, support increased
22 distribution of naloxone and many other efforts. Therefore, your Reference Committee
23 recommends reaffirmation of H-315.983, H-440.813, and H-95.932 in lieu of Resolution
24 219.

25 26 **Patient Privacy and Confidentiality H-315.983**

27
28 1. Our AMA affirms the following key principles that should be consistently
29 implemented to evaluate any proposal regarding patient privacy and the
30 confidentiality of medical information: (a) That there exists a basic right of
31 patients to privacy of their medical information and records, and that this right
32 should be explicitly acknowledged; (b) That patients' privacy should be honored
33 unless waived by the patient in a meaningful way or in rare instances when
34 strong countervailing interests in public health or safety justify invasions of
35 patient privacy or breaches of confidentiality, and then only when such invasions
36 or breaches are subject to stringent safeguards enforced by appropriate
37 standards of accountability; (c) That patients' privacy should be honored in the
38 context of gathering and disclosing information for clinical research and quality
39 improvement activities, and that any necessary departures from the preferred
40 practices of obtaining patients' informed consent and of de-identifying all data be
41 strictly controlled; (d) That any information disclosed should be limited to that
42 information, portion of the medical record, or abstract necessary to fulfill the
43 immediate and specific purpose of disclosure; and (e) That the Health Insurance
44 Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for
45 protecting clinician-patient privilege, regardless of where care is received.

46
47 2. Our AMA affirms: (a) that physicians and medical students who are patients
48 are entitled to the same right to privacy and confidentiality of personal medical
49 information and medical records as other patients, (b) that when patients
50 exercise their right to keep their personal medical histories confidential, such

1 action should not be regarded as fraudulent or inappropriate concealment, and
2 (c) that physicians and medical students should not be required to report any
3 aspects of their patients' medical history to governmental agencies or other
4 entities, beyond that which would be required by law.
5

6 3. Employers and insurers should be barred from unconsented access to
7 identifiable medical information lest knowledge of sensitive facts form the basis of
8 adverse decisions against individuals. (a) Release forms that authorize access
9 should be explicit about to whom access is being granted and for what purpose,
10 and should be as narrowly tailored as possible. (b) Patients, physicians, and
11 medical students should be educated about the consequences of signing overly-
12 broad consent forms. (c) Employers and insurers should adopt explicit and public
13 policies to assure the security and confidentiality of patients' medical information.
14 (d) A patient's ability to join or a physician's participation in an insurance plan
15 should not be contingent on signing a broad and indefinite consent for release
16 and disclosure.
17

18 4. Whenever possible, medical records should be de-identified for purposes of
19 use in connection with utilization review, panel credentialing, quality assurance,
20 and peer review.
21

22 5. The fundamental values and duties that guide the safekeeping of medical
23 information should remain constant in this era of computerization. Whether they
24 are in computerized or paper form, it is critical that medical information be
25 accurate, secure, and free from unauthorized access and improper use.
26

27 6. Our AMA recommends that the confidentiality of data collected by race and
28 ethnicity as part of the medical record, be maintained.
29

30 7. Genetic information should be kept confidential and should not be disclosed to
31 third parties without the explicit informed consent of the tested individual.
32

33 8. When breaches of confidentiality are compelled by concerns for public health
34 and safety, those breaches must be as narrow in scope and content as possible,
35 must contain the least identifiable and sensitive information possible, and must
36 be disclosed to the fewest possible to achieve the necessary end.
37

38 9. Law enforcement agencies requesting private medical information should be
39 given access to such information only through a court order. This court order for
40 disclosure should be granted only if the law enforcement entity has shown, by
41 clear and convincing evidence, that the information sought is necessary to a
42 legitimate law enforcement inquiry; that the needs of the law enforcement
43 authority cannot be satisfied by non-identifiable health information or by any
44 other information; and that the law enforcement need for the information
45 outweighs the privacy interest of the individual to whom the information pertains.
46 These records should be subject to stringent security measures.
47

48 10. Our AMA must guard against the imposition of unduly restrictive barriers to
49 patient records that would impede or prevent access to data needed for medical
50 or public health research or quality improvement and accreditation activities.

1 Whenever possible, de-identified data should be used for these purposes. In
2 those contexts where personal identification is essential for the collation of data,
3 review of identifiable data should not take place without an institutional review
4 board (IRB) approved justification for the retention of identifiers and the consent
5 of the patient. In those cases where obtaining patient consent for disclosure is
6 impracticable, our AMA endorses the oversight and accountability provided by an
7 IRB.

8

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

15

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

26

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

31

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

36

37 15. In the event of the sale or discontinuation of a medical practice, patients
38 should be notified whenever possible and asked for authorization to transfer the
39 medical record to a new physician or care provider. Only de-identified and/or
40 aggregate data should be used for "business decisions," including sales,
41 mergers, and similar business transactions when ownership or control of medical
42 records changes hands.

43

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

49

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

4
5 18. Our AMA supports privacy standards that would require pharmacies to obtain
6 a prior written and signed consent from patients to use their personal data for
7 marketing purposes.

8
9 19. Our AMA supports privacy standards that require pharmacies and drug store
10 chains to disclose the source of financial support for drug mailings or phone calls.

11
12 20. Our AMA supports privacy standards that would prohibit pharmacies from
13 using prescription refill reminders or disease management programs as an
14 opportunity for marketing purposes.

15
16 21. Our AMA will draft model state legislation requiring consent of all parties to
17 the recording of a physician-patient conversation.

18
19 **Public Health Surveillance H-440.813**

20
21 Our AMA: (1) recognizes public health surveillance as a core public health
22 function that is essential to inform decision making, identify underlying causes
23 and etiologies, and respond to acute, chronic, and emerging health threats; (2)
24 recognizes the important role that physicians play in public health surveillance
25 through reporting diseases and conditions to public health authorities; (3)
26 encourages state legislatures to engage relevant state and national medical
27 specialty societies as well as public health agencies when proposing mandatory
28 reporting requirements to ensure they are based on scientific evidence and meet
29 the needs of population health; (4) recognizes the need for increased federal,
30 state, and local funding to modernize our nation's public health data systems to
31 improve the quality and timeliness of data; (5) supports electronic case reporting,
32 which alleviates the burden of case reporting on physicians through the
33 automatic generation and transmission of case reports from electronic health
34 records to public health agencies for review and action in accordance with
35 applicable health care privacy and public health reporting laws; (6) will share
36 updates with physicians and medical societies on public health surveillance and
37 the progress made toward implementing electronic case reporting.

38
39 **Increasing Availability of Naloxone H-95.932**

40
41 1. Our AMA supports legislative, regulatory, and national advocacy efforts to
42 increase access to affordable naloxone, including but not limited to collaborative
43 practice agreements with pharmacists and standing orders for pharmacies and,
44 where permitted by law, community-based organizations, law enforcement
45 agencies, correctional settings, schools, and other locations that do not restrict
46 the route of administration for naloxone delivery.

47
48 2. Our AMA supports efforts that enable law enforcement agencies to carry and
49 administer naloxone.

50

- 1 3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of
2 overdose and, where permitted by law, to the friends and family members of
3 such patients.
4
- 5 4. Our AMA encourages private and public payers to include all forms of
6 naloxone on their preferred drug lists and formularies with minimal or no cost
7 sharing.
8
- 9 5. Our AMA supports liability protections for physicians and other health care
10 professionals and others who are authorized to prescribe, dispense and/or
11 administer naloxone pursuant to state law.
- 12 6. Our AMA supports efforts to encourage individuals who are authorized to
13 administer naloxone to receive appropriate education to enable them to do so
14 effectively.
15
- 16 7. Our AMA encourages manufacturers or other qualified sponsors to pursue the
17 application process for over the counter approval of naloxone with the Food and
18 Drug Administration.
19
- 20 8. Our AMA supports the widespread implementation of easily accessible
21 Naloxone rescue stations (public availability of Naloxone through wall-mounted
22 display/storage units that also include instructions) throughout the country
23 following distribution and legislative edicts similar to those for Automated
24 External Defibrillators.
25
- 26 9. Our AMA supports the legal access to and use of naloxone in all public spaces
27 regardless of whether the individual holds a prescription.
28
29

RECOMMENDED FOR ADOPTION IN LIEU OF

- 1
2
3 (17) RESOLUTION 201 – ENSURING CONTINUED
4 ENHANCED ACCESS TO HEALTHCARE VIA
5 TELEMEDICINE AND TELEPHONIC COMMUNICATION
6

7 **RECOMMENDATION:**

8
9 **Alternate Resolution 201 be adopted in lieu of**
10 **Resolution 201 to read as follows:**

11
12 **RESOLVED, That our American Medical Association advocate that the**
13 **HIPAA enforcement moratorium for telehealth services be extended by**
14 **at least 365 days after the end of the COVID-19 Public Health Emergency,**
15 **during which time physicians and other affected parties shall not be**
16 **subject to HIPAA audits and other HIPAA enforcement activity relative to**
17 **telehealth.**

18
19 **HOD ACTION: Alternate Resolution 201 adopted in lieu of**
20 **Resolution 201**

21
22 **RESOLVED, That our American Medical Association address the importance of at least**
23 **a 365-day waiting period after the COVID-19 public health crisis is over before**
24 **commencement of audits aimed at discovering the use of non-HIPAA compliant modes**
25 **and platforms of telemedicine by physicians. (Directive to Take Action)**
26

27 Your Reference Committee heard positive testimony on the spirit of Resolution 201.
28 Your Reference Committee heard that our AMA has advocated in support of a transition
29 period to allow providers to come into compliance with HIPAA after the end of the public
30 health emergency without penalty. Your Reference Committee also heard that our AMA
31 does not have established policy on whether it should advocate for a transition period at
32 the close of the public health emergency. Your Reference Committee heard positive
33 testimony on the importance of delaying potential audits and the need to ensure a
34 transition period so that telehealth services can continue for patients who do not have
35 access to HIPAA compliant platforms. Testimony was offered in support of alternate
36 language that would further clarify our AMA's goal of allowing physicians time to
37 transition to HIPAA compliant platforms without the threat of HIPAA audits or other
38 HIPAA enforcement activity. While your Reference Committee heard additional
39 testimony in support of language that would not specify a minimum time for the transition
40 period, your Reference Committee agrees with the testimony offered in support of the
41 365-day minimum transition period in Resolution 201. Your Reference Committee
42 determined that an alternate resolution would better reflect the intent of the original
43 resolution while addressing additional testimony calling on our AMA to continue
44 advocating that physicians are not subject to HIPAA audits and other HIPAA
45 enforcement activity during the transition period. Therefore, your Reference Committee
46 recommends adoption of alternate Resolution 201 in lieu of Resolution 201.

1 (18) RESOLUTION 218 – ADVOCATING FOR
2 ALTERNATIVES TO IMMIGRANT DETENTION
3 CENTERS THAT RESPECT HUMAN DIGNITY
4

5 **RECOMMENDATION A:**
6

7 **AMA Policy H-350.955 be amended by addition of a**
8 **fifth clause to read as follows:**
9

10 **1. Our AMA recognizes the negative health consequences of the detention**
11 **of families seeking safe haven.**
12

13 **2. Due to the negative health consequences of detention, our AMA opposes**
14 **the expansion of family immigration detention in the United States.**
15

16 **3. Our AMA opposes the separation of parents from their children who are**
17 **detained while seeking safe haven.**
18

19 **4. Our AMA will advocate for access to health care for women and children**
20 **in immigration detention.**
21

22 **5. Our AMA will advocate for the preferential use of Alternatives to**
23 **Detention programs that respect the human dignity of immigrants,**
24 **migrants, and asylum seekers who are in the custody of federal agencies.**
25 **(Directive to Take Action)**
26

27 **RECOMMENDATION B:**
28

29 **Policy H-350.955 be adopted as amended in lieu of**
30 **Resolution 218.**
31

32 **RECOMMENDATION C:**
33

34 **Title of Policy H-350.955 be changed to read as**
35 **follows:**
36

37 **~~Care of Women and Children in Family~~ Policy Regarding Immigration**
38 **Detention**
39

40 **HOD ACTION: Policy H-350.955 adopted as amended with**
41 **change in title in lieu of Resolution 218**
42

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

47
48 Your Reference Committee heard that Resolution 218 aligns with current AMA policy
49 and advocacy efforts surrounding the health of immigrant populations at the border. Your
50 Reference Committee also heard that our AMA has strongly advocated in opposition to

1 family separation at ICE immigrant detention centers, detainment of undocumented
2 immigrant children, and supports finding alternatives to holding individuals within
3 detainment centers due to the negative health consequences of being held in detention.
4 Your Reference Committee heard individual testimony that noted this issue may be
5 better evaluated through a formal report; however, several delegates noted that our AMA
6 is already active in issues related to immigration and our policy would benefit from this
7 addition. Your Reference Committee also heard testimony that there was relevant AMA
8 policy that could be amended to include the proposed language of this resolution. As
9 such, your Reference Committee recommends that, to consolidate policy, Resolution
10 218 be incorporated into current AMA Policy H-350.955. Additionally, your Reference
11 Committee recommends that AMA Policy H-350.955 be adopted as amended with a
12 change of title that reflects the policy's broader application.
13

1 Mister Speaker, this concludes the report of Reference Committee B. I would like to
2 thank Tina Shah, MD, Venkat Rao, MD, Michael Medlock, MD, George Fouras, MD,
3 Seth Flagg, MD, Mark Dobbertien, MD, and all those who testified before the Committee.
4
5

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California

Venkat Rao, MD
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Michael Medlock, MD (Alternate)
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