DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2021 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

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1 Your Reference Committee recommends the following consent calendar for acceptance:
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3 **RECOMMENDED FOR ADOPTION**
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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

1 **RECOMMENDED FOR ADOPTION**
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3 (1) BOT 7 – COUNCIL ON LEGISLATION SUNSET REVIEW
4 OF 2011 HOUSE POLICIES
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6 **RECOMMENDATION:**
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8 **Recommendation in Board of Trustees Report 7 be**
9 **adopted and the remainder of the report be filed.**
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11 The Board of Trustees recommends that the House of Delegates policies that are listed in
12 the appendix to this report be acted upon in the manner indicated and the remainder of
13 this report be filed.
14
15 Your Reference Committee considered Board of Trustees Report 7 and agrees with the
16 recommendations for the policies in the Sunset Review. Your Reference Committee,
17 therefore, recommends adoption of Board of Trustees Report 7.
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19 (2) RESOLUTION 213 – CMMI PAYMENT REFORM
20 MODELS
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22 **RECOMMENDATION:**
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24 **Resolution 213 be adopted.**
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26 RESOLVED, That our American Medical Association continue to advocate against
27 mandatory CMMI demonstration projects (Directive to Take Action); and be it further
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29 RESOLVED, That our AMA advocate that CMS seek innovative payment and care
30 delivery model ideas from physicians and groups such as medical specialty societies to
31 guide recommendation of the PTAC and work of the CMMI to propose demonstration
32 projects that are voluntary and can be appropriately tested (Directive to Take Action); and
33 be it
34
35 RESOLVED, That our AMA advocate that CMMI focus on the development of multiple
36 pilot projects in many specialties, which are voluntary and tailored to the needs of local
37 communities and the needs of different specialties. (Directive to Take Action)
38
39 Your Reference Committee heard how Resolution 213 addresses efforts to advocate
40 against mandatory Centers for Medicare & Medicaid Services (CMS) Innovation Center
41 (CMMI) demonstration projects and to further advocate for CMS to seek innovative
42 payment and care delivery models from physician groups to help guide the work of CMMI
43 as they propose voluntary demonstration projects that can be appropriately tested and
44 advocate for CMMI to focus on the development of multiple pilot projects across many
45 specialties, which are voluntary and tailored to the needs of local communities. Your
46 Reference Committee heard that this resolution is consistent with existing AMA policy and
47 advocates that CMS work with Physician-Focused Payment Model Technical Advisory
48 Committee (PTAC) to guide CMMI to develop physician-designed models that could
49 benefit Medicare and Medicaid patients. Your Reference Committee heard how our AMA
50 is actively engaged with the physician community and has worked extensively with

medical specialty societies, other physician groups, and Congress to support the development of well-designed Alternative Payment Model (APM) proposals that are consistent with the goals of the Medicare and CHIP Reauthorization Act (MACRA) passed in 2015. Moreover, your Reference Committee heard how our AMA developed recommendations for the new Administration to consider that address issues with the implementation of APMs. Therefore, your Reference Committee recommends that Resolution 213 be adopted.

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

RECOMMENDATION:

Resolution 216 be adopted.

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

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

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

RECOMMENDATION:

Resolution 217 be adopted.

RESOLVED, That our American Medical Association amend policy H-150.962, "Quality of School Lunch Program," by addition as follows:

Quality of School Lunch Program H-150.962

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

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

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

RECOMMENDATION:

Resolution 232 be adopted.

1 RESOLVED, That our American Medical Association advocate to prohibit the use of
2 patient/customer information collected by retail pharmacies for COVID-19 vaccination
3 scheduling and/or the vaccine administration process for commercial marketing or future
4 patient recruiting purposes, especially any targeting based on medical history or
5 conditions (Directive to Take Action); and be it further
6
7 RESOLVED, That our AMA oppose the sale of medical history data and contact
8 information accumulated through the scheduling or provision of government-funded
9 vaccinations to third parties for use in marketing or advertising (New HOD Policy).
10
11 Your Reference Committee heard overwhelming testimony in support of Resolution 232.
12 Your Reference Committee heard testimony that our AMA has been actively advocating
13 to ensure that as health information is shared—particularly outside of the health care
14 system—patients have meaningful controls over and a clear understanding of how their
15 data is being used and with whom it is being shared; and that above all, patients feel
16 confident that their health information will remain private. Your Reference Committee
17 heard testimony that our AMA has been vocal in discussions with current and previous
18 Administration officials on proposed rules, regulations, and guidance documents to ensure
19 that patient privacy is at the forefront of any federal policy decisions. Therefore, your
20 Reference Committee recommends that Resolution 232 be adopted.
21
22 (6) RESOLUTION 233 – NON-PHYSICIAN TITLE
23 MISAPPROPRIATION
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25 **RECOMMENDATION:**
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27 **Resolution 233 be adopted.**
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29 RESOLVED, That our American Medical Association actively oppose the American
30 Academy of Physician Assistants' (AAPA's) recent move to change the official title of the
31 profession from "Physician Assistant" to "Physician Associate" (Directive to Take Action);
32 and be it further
33
34 RESOLVED, That our AMA actively advocate that the stand-alone title "Physician" be
35 used only to refer to doctors of allopathic medicine (MDs) and doctors of osteopathic
36 medicine (DOs), and not be used in ways that have the potential to mislead patients about
37 the level of training and credentials of non-physician health care workers. (Directive
38 to Take Action)
39
40 Your Reference Committee heard extensive and near unanimous testimony in strong
41 support of Resolution 233. Your Reference Committee heard multiple examples of how
42 Resolution 233 directly aligns with our AMA's statement issued on July 3, 2021 opposing
43 the AAPA's recent title change and our extensive policy supporting strong truth in
44 advertising laws. Your Reference Committee also heard of the importance of limiting the
45 title "physician" to MDs and DOs. Additionally, your Reference Committee heard that
46 Resolution 233 aligns with our ongoing commitment to opposing inappropriate expansions
47 of scope of practice and supporting our Truth in Advertising campaign. Therefore, your
48 Reference Committee recommends that Resolution 233 be adopted.
49

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

(7) BOT 14 – PHARMACEUTICAL ADVERTISING IN ELECTRONIC HEALTH RECORD SYSTEMS

RECOMMENDATION A:

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

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

RECOMMENDATION B:

Recommendation in Board of Trustees Report 14 be adopted as amended and the remainder of the report be filed.

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

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

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

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

RECOMMENDATION A:

Recommendations in Board of Trustees Report 18 be amended by addition of a fourth recommendation to read as follows:

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

RECOMMENDATION B:

Recommendations in Board of Trustees Report 18 be adopted in lieu of Resolution 230 and the remainder of the report be filed.

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

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

Your Reference Committee heard overwhelming testimony in support of BOT Report 18 and mixed testimony regarding Resolution 230. Your Reference Committee heard testimony that BOT 18 provides a cautionary analysis of two widely popular approaches for responding to the ongoing COVID-19 pandemic. Your Reference Committee heard that both vaccine credentials and mandatory vaccination strategies serve compelling public interests: protecting the health of the community while allowing individuals

expanded opportunities for social and economic interaction. Your Reference Committee heard testimony that both strategies also pose ethical and practical challenges, notably to confidentiality and autonomy, and have the potential to adversely and disproportionately affect members of marginalized and minoritized communities. Your Reference Committee heard testimony that Resolution 230 addresses the same issues as BOT 18 and includes a recommendation about natural immunity credentials that should be added as a fourth recommendation in BOT 18 to enhance our AMA's policy. Therefore, your Reference Committee recommends that BOT 18 be amended by addition of a fourth recommendation that addresses the goal of Resolution 230 with regards to natural immunity. Your Reference Committee further recommends that BOT 18 as amended be adopted in lieu of Resolution 230 and the remainder of the report be adopted and filed.

(9) RESOLUTION 206 – REDEFINING THE DEFINITION OF HARM
RESOLUTION 212 – ONC'S INFORMATION BLOCKING REGULATIONS

RECOMMENDATION A:

Resolution 206 be amended by addition and deletion to read as follows:

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

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

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

RECOMMENDATION B:

Resolution 206 be adopted as amended in lieu of Resolution 212.

Resolution 206

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

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

Resolution 212
RESOLVED, That our American Medical Association advocate for additional time and compliance leeway for physicians by urging the Office of the National Coordinator for Health Information Technology (ONC) to broaden and relax their current regulatory requirements based on the following critical enumerated requests:

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

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

(10) RESOLUTION 210 – RANSOMWARE AND ELECTRONIC HEALTH RECORDS

RECOMMENDATION A:

Resolution 210 be amended by addition and deletion to read as follows:

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

RESOLVED, That our AMA advocate for ~~seek to introduce~~ federal legislation which provides for the prosecution of perpetrators of ransomware and any other malware on any and all healthcare entities, involved in direct and

indirect patient care, to the fullest extent of the law. (Directive to Take Action)

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

RECOMMENDATION B:

Resolution 210 be adopted as amended.

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

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

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

(11) RESOLUTION 215 – EXEMPTIONS TO WORK REQUIREMENTS AND ELIGIBILITY EXPANSIONS IN PUBLIC ASSISTANCE PROGRAMS

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association support ~~reduction and~~ elimination of work requirements ~~applied to the~~ used as eligibility criteria in public assistance programs, including the Supplemental Nutrition

Assistance Program (SNAP) and the Temporary Assistance for Needy Families Program (TANF) (New HOD Policy); and be it further

RECOMMENDATION B:

Resolution 215 be amended by the addition of a third Resolve.

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

RECOMMENDATION C:

Resolution 215 be adopted as amended.

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

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

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

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

RECOMMENDATION A:

Resolution 226 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

Resolution 226 be adopted as amended.

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

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

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

RECOMMENDATION A:

Resolution 227 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

Resolution 227 be amended by addition of a second Resolve to read as follows:

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

RECOMMENDATION C:

Resolution 227 be adopted as amended.

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

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

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

RECOMMENDATION A:

Resolution 228 be amended by addition and deletion to read as follows:

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

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

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

RECOMMENDATION B:

Resolution 228 be adopted as amended.

RECOMMENDATION C:

AMA Policies D-440.921 and H-440.875 be reaffirmed.

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

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

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

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

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

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of “experimentation”

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

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

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

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

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

4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).
5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.

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

7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of

covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.

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

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

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

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

RECOMMENDATION A:

Resolution 229 be amended by addition and deletion to read as follows:

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

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

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

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

RECOMMENDATION B:

Resolution 229 be adopted as amended.

RECOMMENDATION C:

AMA Policies D-420.993, H-430.986, H-315.983, and H-60.909 be reaffirmed.

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

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

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

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

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

Your Reference Committee heard testimony that while obtaining more pregnant inmate data is a laudable goal for our organization, our AMA also has policy protecting the privacy of such individuals from discrimination due to the use of such data by U.S. Immigration and Customs Enforcement (ICE) or other agencies, and therefore any policy surrounding data collection, particularly surrounding vulnerable populations, must have robust privacy protections. Therefore, your Reference Committee recommends that D-420.993, H-

430.986, H-315.983 and H-60.909 be reaffirmed in lieu of Resolved 1 and 2 of Resolution 229; and that Resolved 3 and 4 be adopted as amended.

Disparities in Maternal Mortality D-420.993

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

Health Care While Incarcerated H-430.986

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

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

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

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

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

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

7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.

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

Patient Privacy and Confidentiality H-315.983

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

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

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and

medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

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

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

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

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

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

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

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

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and

treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures

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

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

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

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

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

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

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

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

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

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

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.

1 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**
2
3 (16) RESOLUTION 219 – OPPOSE TRACKING OF PEOPLE
4 WHO PURCHASE NALOXONE
5
6 **RECOMMENDATION:**
7
8 **That AMA Policies H-315.983, H-440.813, and H-95.932**
9 **be reaffirmed in lieu of Resolution 219.**
10
11 RESOLVED, That our American Medical Association oppose any policies that require
12 personally identifiable information associated with naloxone prescriptions or purchases to
13 be tracked or monitored by non-health care providers. (New HOD Policy)
14
15 Your Reference Committee heard testimony in strong support of the intent of Resolution
16 219. Your Reference Committee heard testimony supportive regarding the overall need to
17 increase access to and safeguard patient privacy and confidentiality with respect to a
18 prescription for naloxone. Your Reference Committee agrees that an individual should not
19 be discriminated against because his or her prescription history includes a prescription for
20 naloxone. Your Reference Committee further agrees that naloxone should be available
21 over-the-counter (OTC) to help increase access to naloxone.
22
23 Your Reference Committee heard that our AMA is deeply engaged in each of these issues.
24 Your Reference Committee heard testimony that, while utilizing our current policy on
25 safeguarding patient privacy and confidentiality (H-315.983 Patient Privacy and
26 Confidentiality), our AMA has been able to advocate to the National Association of
27 Insurance Commissioners that a prescription for naloxone should never be tracked or
28 used by itself to adversely affect an individual in any line of insurance. Your Reference
29 Committee heard that Massachusetts and Colorado are two states that have issued
30 bulletins based on AMA advocacy, making this point clear to all insurance carriers in those
31 states. Your Reference Committee heard that our AMA will take similar action in any other
32 state where this becomes an issue. Your Reference Committee agrees that a naloxone
33 prescription—by itself—is not indicative whether an individual is at risk of an opioid-related
34 overdose.
35
36 Your Reference Committee heard that our AMA continues to advocate for comprehensive
37 public health and data surveillance on multiple aspects of the nation's drug overdose
38 epidemics, actions which include hosting broad, national stakeholder meetings to identify
39 best practices, advocate for standardization, and urging states to use de-identified non-
40 fatal and fatal overdose data to identify areas where targeted prevention, treatment and
41 harm reduction resources are needed. Your Reference Committee heard that current
42 policy H-440.813, Public Health Surveillance, has been utilized to advocate on issues of
43 public health and data surveillance issues to groups ranging from the National Governors
44 Association to the National Association of Attorneys General and the Pew Charitable
45 Trusts.
46
47 Your Reference Committee heard that the position of our AMA on the accessibility of
48 naloxone over the counter, current policy H-95.932, Increasing Availability of Naloxone,
49 makes clear that "Our AMA encourages manufacturers or other qualified sponsors to
50 pursue the application process for over the counter approval of naloxone with the Food

and Drug Administration." Your Reference Committee considered that our AMA has supported and promoted FDA's actions to create labeling and other information to support manufacturers to submit over the counter applications.

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

Patient Privacy and Confidentiality H-315.983

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

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

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public

policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

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

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

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

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

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

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

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

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

their uncoerced permission after being fully informed about the purpose of such disclosures

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

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

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

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

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

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

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

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

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

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

Public Health Surveillance H-440.813

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

Increasing Availability of Naloxone H-95.932

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

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

3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.

4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.

5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.

6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.

7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.

8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.

9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.

1 **RECOMMENDED FOR ADOPTION IN LIEU OF**
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 <u>adopted</u> 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 subject**
16 **to HIPAA audits and other HIPAA enforcement activity relative to telehealth.**
17
18 RESOLVED, That our American Medical Association address the importance of at least a
19 365-day waiting period after the COVID-19 public health crisis is over before
20 commencement of audits aimed at discovering the use of non-HIPAA compliant modes
21 and platforms of telemedicine by physicians. (Directive to Take Action)
22
23 Your Reference Committee heard positive testimony on the spirit of Resolution 201. Your
24 Reference Committee heard that our AMA has advocated in support of a transition period
25 to allow providers to come into compliance with HIPAA after the end of the public health
26 emergency without penalty. Your Reference Committee also heard that our AMA does not
27 have established policy on whether it should advocate for a transition period at the close
28 of the public health emergency. Your Reference Committee heard positive testimony on
29 the importance of delaying potential audits and the need to ensure a transition period so
30 that telehealth services can continue for patients who do not have access to HIPAA
31 compliant platforms. Testimony was offered in support of alternate language that would
32 further clarify our AMA's goal of allowing physicians time to transition to HIPAA compliant
33 platforms without the threat of HIPAA audits or other HIPAA enforcement activity. While
34 your Reference Committee heard additional testimony in support of language that would
35 not specify a minimum time for the transition period, your Reference Committee agrees
36 with the testimony offered in support of the 365-day minimum transition period in
37 Resolution 201. Your Reference Committee determined that an alternate resolution would
38 better reflect the intent of the original resolution while addressing additional testimony
39 calling on our AMA to continue advocating that physicians are not subject to HIPAA audits
40 and other HIPAA enforcement activity during the transition period. Therefore, your
41 Reference Committee recommends adoption of alternate Resolution 201 in lieu of
42 Resolution 201.

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

RECOMMENDATION A:

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

1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.

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

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

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

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

RECOMMENDATION B:

Policy H-350.955 be adopted as amended in lieu of Resolution 218.

RECOMMENDATION C:

Title of Policy H-350.955 be changed to read as follows:

~~Care of Women and Children in Family~~ Policy Regarding Immigration Detention

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

Your Reference Committee heard that Resolution 218 aligns with current AMA policy and advocacy efforts surrounding the health of immigrant populations at the border. Your Reference Committee also heard that our AMA has strongly advocated in opposition to family separation at ICE immigrant detention centers, detainment of undocumented immigrant children, and supports finding alternatives to holding individuals within detainment centers due to the negative health consequences of being held in detention. Your Reference Committee heard individual testimony that noted this issue may be better evaluated through a formal report; however, several delegates noted that our AMA is

1 already active in issues related to immigration and our policy would benefit from this
2 addition. Your Reference Committee also heard testimony that there was relevant AMA
3 policy that could be amended to include the proposed language of this resolution. As such,
4 your Reference Committee recommends that, to consolidate policy, Resolution 218 be
5 incorporated into current AMA Policy H-350.955. Additionally, your Reference Committee
6 recommends that AMA Policy H-350.955 be adopted as amended with a change of title
7 that reflects the policy's broader application.
8

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

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