

APPENDIX - REPORTS OF REFERENCE COMMITTEES

June 2021 Special Meeting of the American Medical Association House of Delegates

Reference committee reports from the House of Delegates meeting are provided for the sake of convenience and because they are part of the record of each meeting.

The Proceedings reflect the official record of the actions taken by the House of Delegates at a given meeting and have precedence. Discrepancies between the reference committee reports and the Proceedings may exist, as the Proceedings are prepared using multiple sources, including a transcript of debate. Policies deriving from House actions are recorded in PolicyFinder, which is updated following each House of Delegates meeting.

Note: The original language of report recommendations and the original resolve clauses from resolutions are included in the reference committee reports with a light-colored background as in the example below:

The Board of Trustees recommends that the following be adopted in lieu of the resolution and the remainder of this report be filed.

In addition, where the reference committee proposes changes in addition or different from changes proposed by the original item of business, those changes are shown with double underscore or double ~~striethrough~~, and in some cases are highlighted in **yellow**.

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 17 – SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES – FIVE-YEAR REVIEW

RECOMMENDATION:

Recommendations in Board of Trustees Report 17 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 17 adopted and the remainder of the Report filed

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

1. That AMDA – The Society for Post-Acute and Long-Term Care Medicine, American Academy of Child and Adolescent Psychiatry, American Association of Clinical Endocrinology, American Association of Physicians of Indian Origin, American College of Medical Genetics and Genomics, American College of Radiation Oncology, American Institute of Ultrasound in Medicine, American Orthopaedic Foot and Ankle Society, American Society for Clinical Pathology, American Society of Anesthesiologists, American Society of Cataract and Refractive Surgery, American Society of Colon and Rectal Surgeons, American Society of Dermatopathology, American Society of Neuroradiology, Obesity Medicine Association, 34 Renal Physicians Association, Society of Critical Care Medicine, and the Society of Interventional Radiology retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

The report was introduced by the Board, and no further testimony was heard. Your Reference Committee recommends that the recommendations in Board of Trustees Report 17 be adopted and the remainder of the report be filed.

- (2) COUNCIL ON CONSTITUTION & BYLAWS REPORT 1 – BYLAW ACCURACY: SINGLE ACCREDITATION ENTITY FOR ALLOPATHIC AND OSTEOPATHIC GRADUATE MEDICAL EDUCATION PROGRAMS

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Council on Constitution and Bylaws Report 1 adopted and the remainder of the Report filed.

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

7.1 Resident and Fellow Section. The Resident and Fellow Section is a fixed Section.

7.1.1 Membership. All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.

7.1.1.1 Definition of a Resident. For purposes of membership in the Resident and Fellow Section, the term Resident shall be applied to any physicians who meet at least one of the following criteria:

- a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education ~~or the American Osteopathic Association.~~
- b) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including underseas medical officers or flight surgeons) before their return to complete a residency.
- c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.

7.1.1.2 Definition of a Fellow. For purposes of membership in the Resident and Fellow Section, the term Fellow shall be applied to any physicians who have completed a residency and meet at least one of the following criteria:

- a) Members who are serving in fellowships approved by the Accreditation Council for Graduate Medical Education ~~or the American Osteopathic Association.~~
- b) Members who are serving, as their primary occupation, in a structured clinical, educational, vocational, or research training program of at least six months to broaden competency in a specialized field.

The report was introduced by the authors and no further testimony was heard. Your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws report 1 be adopted and the remainder of the report be filed.

- (3) COUNCIL ON CONSTITUTION & BYLAWS REPORT 3 –
CLARIFICATION TO BYLAW 7.5.2, CESSATION OF ELIGIBILITY (FOR
THE YOUNG PHYSICIANS SECTION)

RECOMMENDATION:

Recommendations in Council on Constitution and Bylaws Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Constitution and Bylaws Report 3 adopted and the remainder of the report filed.

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

7.5 Young Physicians Section. The Young Physicians Section is a fixed Section.

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

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

7.5.2.1 The chair position is a three-year commitment and divided into the roles of chair-elect, chair, and immediate past chair. The young physician must meet the requirements of Bylaws 7.5.1 and 7.5.2 through the end of the chair

role, or 2nd year. The immediate past chair shall be permitted to complete the term of office even if unable to continue to meet all of the requirements of Bylaw 7.5.1, as long as the physician remains an active physician member of the AMA.

Testimony was heard in general opposition to this report, requesting that the report be amended to allow one extra year of eligibility, which would be a more adequate timeframe for participation and eventual leadership in the YPS and noted that the section should be given the opportunity to pick their own leadership. Testimony was also offered that the additional language included in the report would disadvantage women, who often begin their participation in YPS later. Those who opposed adoption of this report supported adoption of Resolution 24, which reflects the will of the YPS.

Council on Constitution and Bylaws presented its report and noted that it was the request of CEJA to clarify existing Bylaws. In addition, the Council noted that while these Bylaws have been clarified, there were other related Bylaws that also pertained to this topic. While adoption of this report does not preclude Resolution 24 from being adopted, the Council noted that it does serve to resolve ambiguity in the Bylaws. Your Reference Committee also notes that if Resolution 24 is adopted the Bylaws would still need to be further reviewed in order to achieve the intent of Resolution 24. The Council stated that Bylaws 7.0.4 and 7.0.4.1 specifically states that all Chairs of the sections must be members of the section. This Bylaw would need to be reconciled in order to accomplish the goal of Resolution 24. Your Reference Committee sees adoption of Council on Constitution and Bylaws Report 3 as necessary clarification to our Bylaws regardless of the outcome of Resolution 24, and recommends that Council on Constitution and Bylaws report 3 be adopted.

- (4) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 – SHORT-TERM MEDICAL SERVICE TRIPS

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 2 referred.

In light of these deliberations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

Short-term medical service trips, which send physicians and physicians in training from wealthier countries to provide care in resource-limited settings for a period of days or weeks, have emerged as a prominent strategy for addressing global health inequities. They also provide training and educational opportunities, thus offering benefit both to the communities that host them and the medical professionals and trainees who volunteer their time and clinical skills.

By definition, short-term medical service trips take place in contexts of scarce resources and vulnerable communities. The realities of scarcity and vulnerability define fundamental ethical responsibilities to enable good health outcomes, promote justice and sustainability, minimize burdens on host communities, and respect persons and local cultures. Responsibly carrying out short-term medical service trips requires diligent preparation on the part of sponsors and participants in collaboration with host communities.

Physicians and trainees who are involved with short-term medical service trips should ensure that the trips with which they are associated:

- (a) Focus prominently on promoting justice and sustainability by collaborating with the host community to define mission parameters, including identifying community needs, mission goals, and how the volunteer medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term medical service trips should identify opportunities for and priority of efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing

educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the volunteer medical team.

- (b) Seek to proactively identify and minimize burdens the trip may place on the host community, including not only direct, material costs of hosting volunteers, but on possible disruptive effects the presence of volunteers could have for local practice and practitioners as well. Sponsors and participants should ensure that team members bring appropriate skill sets and experience, and that resources are available to support the success of the trip, including arranging for local mentors, translation services, and volunteers' personal health needs as appropriate.
- (c) Seek to become broadly knowledgeable about the communities in which they will work and take advantage of resources to begin to cultivate the "cultural sensitivity" they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the volunteer medical team are expected to uphold the ethics standards of their profession and volunteers should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, volunteers may withdraw from care of an individual patient or from the mission after careful consideration of the effect that will have on the patient, the medical team, and the mission overall, in keeping with ethics guidance on the exercise of conscience.

Sponsors of short-term medical service trips should:

- (d) Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally
- (e) Proactively define appropriate roles and permissible range of practice for members of the volunteer team, including the training, experience, and oversight of team members required to provide acceptable safe, high quality care in the host setting. Team members should practice only within the limits of their training and skills in keeping with the professional standards of the sponsor's country.
- (f) Put in place a mechanism to collect data on success in meeting collaboratively defined goals for the trip in keeping with recognized standards for the conduct of health services research and quality improvement activities in the sponsor's country.

Testimony was generally supportive of this report. Testimony in support noted that short-term medical service trips were important, and that anything that the AMA could do to support them was positive. Testimony was also heard for referral and suggested that the report should strongly underline the decolonization of global health and the history of medical colonialism, as well as the need to address scope of practice. Your Reference Committee acknowledges the significance of these issues, yet believes that benefits of this report are significant and timely, and therefore recommends that the recommendations in Council on Ethical and Judicial Affairs Report 2 be adopted and the remainder of the report be filed.

- (5) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3 – AMENDMENT TO OPINION E-9.3.2, "PHYSICIAN RESPONSIBILITIES TO IMPAIRED COLLEAGUES"

RECOMMENDATION:

Recommendations in Council on Ethical and Judicial Affairs Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 3 adopted and the remainder of the report filed.

The Council on Ethical and Judicial Affairs Recommends that Opinion 9.3.2, "Physician Responsibilities to Impaired Colleagues," be retitled as "Physician Responsibilities to Colleagues with Illness, Disability or Impairment" and amended by substitution as follows; and the remainder of this report be filed:

Providing safe, high quality care is fundamental to physicians' fiduciary obligation to promote patient welfare. Yet a variety of physical and mental health conditions—including physical disability, medical illness, and substance use—can undermine physicians' ability to fulfill that obligation. These conditions in turn can put patients at risk, compromise physicians' relationships with patients, as well as colleagues, and undermine public trust in the profession.

While some conditions may render it impossible for a physician to provide care safely, with appropriate accommodations or treatment many can responsibly continue to practice, or resume practice once those needs have been met. In carrying out their responsibilities to colleagues, patients, and the public, physicians should strive to employ a process that distinguishes conditions that are permanently incompatible with the safe practice of medicine from those that are not and respond accordingly.

As individuals, physicians should:

- (a) Maintain their own physical and mental health, strive for self-awareness, and promote recognition of and resources to address conditions that may cause impairment.
- (b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping with ethics guidance on physician health and competence.
- (c) Intervene with respect and compassion when a colleague is not able to practice safely. Such intervention should strive to ensure that the colleague is no longer endangering patients and that the individual receive appropriate evaluation and care to treat any impairing conditions.
- (d) Protect the interests of patients by promoting appropriate interventions when a colleague continues to provide unsafe care despite efforts to dissuade them from practice.
- (e) Seek assistance when intervening, in keeping with institutional policies, regulatory requirements, or applicable law.

Collectively, physicians should nurture a respectful, supportive professional culture by:

- (f) Encouraging the development of practice environments that promote collegial mutual support in the interest of patient safety.
- (g) Encouraging development of inclusive training standards that enable individuals with disabilities to enter the profession and have safe, successful careers.
- (h) Eliminating stigma within the profession regarding illness and disability.
- (i) Advocating for supportive services and accommodations to enable physicians who require assistance to provide safe, effective care.
- (j) Advocating for respectful and supportive, evidence-based peer review policies and practices that will ensure patient safety and practice competency.

Mixed testimony was heard on this report. Those speaking in support noted that the report was incredibly important, addressed a range of issues that can affect physicians, moves away from ableism and toward inclusivity, and is in alignment with the AMA Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity ("Health Equity Plan"). Testimony was also heard in support of referral, noting that physicians must have the opportunity for assessment by independent organizations without conflicts of interest, rather than by the physician's employer or institution. Your Reference Committee acknowledges that the issue of independent assessment is significant and would encourage CEJA to consider evaluating this issue in the future but believes the report as written addresses important and timely issues and should not be delayed. Therefore, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 3 be adopted and the remainder of the report be filed.

(6) RESOLUTION 3 – HEALTHCARE ORGANIZATIONAL POLICIES AND CULTURAL CHANGES TO PREVENT AND ADDRESS RACISM, DISCRIMINATION, BIAS AND MICROAGGRESSIONS

RECOMMENDATION:

Resolution 3 be adopted.

HOD ACTION: Resolution 3 adopted

RESOLVED, That our American Medical Association adopt the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
 - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
 - Define expected and prohibited behavior.
 - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
 - Ensure privacy and confidentiality to the reporter.
 - Provide a confidential method for documenting and reporting incidents.
 - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:

- Taking every complaint seriously.
- Acting upon every complaint immediately.
- Developing appropriate resources to resolve complaints.
- Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
- Communicating decisions and actions taken by the organization following a complaint to all affected parties.
- Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
 - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
 - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.

Providing designated support person to confidentially accompany the person reporting an event through the process. (New HOD Policy)

Mixed testimony was heard on this resolution. Testimony for referral noted that the resolution needs precise definitions and explicit directions based on best evidence on how to implement and comply. Other testimony noted that the length and complexity of the issue may be too much to accomplish in a single resolution, and that more discussion—and specifically in-person discussion—was necessary on such a complex issue. Testimony in support applauded the resolution and noted that the AMA has long recognized the damaging effects of racism in medicine, and the AMA should provide guidance for organizations attempting to eliminate racist policies and promoting a healthy work environment. Other testimony underscored that this resolution presents guidelines rather than binding rules/laws for organizations to follow, and that the AMA should not delay acting on such a significant and urgent issue. Testimony in support also noted that the terms included have been well-established in social science and other literature for decades and are defined within the AMA’s health equity strategic plan. Your Reference Committee acknowledges the complexity of these issues and the necessity for further discussion, but recognizes that this resolution provides guidelines – not mandates – that could be useful for organizations, and thus our AMA should not hesitate to provide this direction. Your Reference Committee therefore recommends that Resolution 3 be adopted.

(7) RESOLUTION 4 – AMA RESIDENT/FELLOW COUNCILOR TERM LIMITS

RECOMMENDATION:**Resolution 4 be adopted.****HOD ACTION: Resolution 4 adopted**

RESOLVED, That our American Medical Association amend the AMA “Constitution and Bylaws” by addition and deletion to read as follows:

6.5 Council on Ethical and Judicial Affairs.**6.5.7 Term.**

6.5.7.2 Except as provided in Bylaw 6.11, the resident/fellow physician member of the Council shall be elected for a term of 23 years provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.5.8 Tenure. Members of the Council may serve only one term, except that the resident/fellow physician member shall be eligible to serve for 3 terms and the medical student member shall be eligible to serve for 2 terms. A member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served at least half of the term.

6.5.9 Vacancies.

6.5.9.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 23-year term. (Modify Bylaws) and be it further

RESOLVED, That our AMA amend the AMA “Constitution and Bylaws” by addition and deletion to read as follows:

6.6 Council on Long Range Planning and Development.**6.6.3 Term.**

6.6.3.2 Resident/Fellow Physician Member. The resident/fellow physician member of the Council shall be appointed for a term of 23 years beginning at the conclusion of the Annual Meeting provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed except as provided in Bylaw 6.11, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.6.5 Vacancies.

6.6.5.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a 23-year term. (Modify Bylaws) and be it further

RESOLVED, That our AMA amend the AMA “Constitution and Bylaws” by addition and deletion to read as follows:

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.2 Resident/Fellow Physician Member. The resident/fellow physician member of these Councils shall be elected for a term of 23 years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.3 Vacancies.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 23-year term. (Modify Bylaws)

Limited testimony was heard in support, and your Reference Committee recommends that Resolution 4 be adopted.

- (8) RESOLUTION 6 – ENSURING CONSENT FOR EDUCATIONAL PHYSICAL EXAMS ON ANESTHETIZED AND UNCONSCIOUS PATIENTS

RECOMMENDATION:

Resolution 6 be adopted.

HOD ACTION: Resolution 6 adopted

RESOLVED, That our American Medical Association oppose performing physical exams on patients under anesthesia or on unconscious patients that offer the patient no personal benefit and are performed solely for teaching purposes without prior informed consent to do so (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage institutions to align current practices with published guidelines, recommendations, and policies to ensure patients are educated on pelvic, genitourinary, and rectal exams that occur under anesthesia (Directive to Take Action); and be it further

RESOLVED, That our AMA strongly oppose issuing blanket bans on student participation in educational physical exams (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm policy H-320.951, “AMA Opposition to “Procedure-Specific” Informed Consent.” (Reaffirm HOD Policy)

Testimony was heard in unanimous support, and your Reference Committee recommends that Resolution 6 be adopted.

- (9) RESOLUTION 9 – SUPPORTING WOMEN AND UNDERREPRESENTED MINORITIES IN OVERCOMING BARRIERS TO POSITIONS OF MEDICAL LEADERSHIP AND COMPETITIVE SPECIALTIES

RECOMMENDATION:

Resolution 9 be adopted.

HOD ACTION: Resolution 9 adopted

RESOLVED, That our American Medical Association advocate for increased research on changes in specialty interests throughout medical education, including both undergraduate and graduate medical education, specifically in competitive specialties, with a focus on student demographics; (Directive to Take Action) and be it further

RESOLVED, That our AMA amend the following policy to in order to support increasing representation and the recruitment of students who identify with groups classically not represented in competitive fields:

H-200.951 Strategies for Enhancing Diversity in the Physician Workforce

Our AMA supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities. Our AMA will both support and take active measures to support medical students who identify with groups underrepresented in competitive specialties, such as women and minority students, in order to take concrete steps to enhance diversity in the physician workforce. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA maintain allocated yearly funding for AMA-MSS national meeting attendance and maintain concrete and standing mechanisms for increasing participation for medical students within our AMA-MSS from medical schools with classically low national meeting attendance, which will be defined as less than five students per national AMA-MSS meeting over a period of five consecutive years, having one or more of the following characteristics:

1. Identify with group(s) underrepresented and disadvantaged in medicine
2. Are from medically underserved areas
3. Are first generation college graduates

as a mechanism to create more exposure to leadership and networking opportunities for these students. (Directive to Take Action)

Testimony was heard in unanimous support of the resolution, noting that many rely on this support, and that physician leadership is not reflective of the demographics of practicing physicians. Your Reference Committee recommends that Resolution 9 be adopted.

- (10) RESOLUTION 15 – OPPOSITION TO THE CRIMINALIZATION AND UNDUE RESTRICTION OF EVIDENCE-BASED GENDER-AFFIRMING CARE FOR TRANSGENDER AND GENDER-DIVERSE INDIVIDUALS

RECOMMENDATION:

Resolution 15 be adopted.

HOD ACTION: Resolution 15 adopted

RESOLVED, That our American Medical Association amend policy H-185.927, “Clarification of Medical Necessity for Treatment of Gender Dysphoria,” by addition and deletion to read as follows:

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; ~~and~~ (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care. (Modify Current HOD Policy)

Testimony was heard in support of the resolution. Testimony noted the urgency of opposing any law that criminalizes or restricts a physician’s ability to provide good-faith, evidence-based care. Additional testimony suggested that it is vital that the AMA continue working to oppose anti-transgender legislation, the introduction of which on the state level has been rising in recent years. Limited testimony was heard in opposition, with speakers expressing hesitation about the ability of children to consent to certain aspects of care, but there were many who spoke about the incredibly harmful effects withholding gender-affirming care has on individuals who seek it. They

highlighted further that the decision to not provide care is a medical decision in and of itself. Your Reference Committee recommends that Resolution 15 be adopted.

(11) RESOLUTION 23 – PANDEMIC ETHICS AND THE DUTY OF CARE

RECOMMENDATION:

Resolution 23 be adopted.

HOD ACTION: Resolution 23 adopted

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

The resolution was introduced by the author, and no further testimony was heard. Your Reference Committee recommends that Resolution 23 be adopted.

(12) RESOLUTION 24 – AMA BYLAWS LANGUAGE ON AMA YOUNG PHYSICIANS SECTION GOVERNING COUNCIL ELIGIBILITY

RECOMMENDATION:

Resolution 24 be adopted.

HOD ACTION: Substitute Resolution 24 adopted to read as follows:

RESOLVED, that the American Medical Association amend the relevant AMA Bylaws to: (1) clarify eligibility of membership in the YPS to be until December 31 of the year of their 40th birthday or December 31 of the eighth year following completion of their graduate medical education, whichever comes later, and (2) reflect that a person who is elected to the Young Physician Section chair-elect position when an eligible member of the Section can complete the chair-elect, chair, and immediate past chair positions even if they have aged out of the Section.

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

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

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

RESOLVED, That the American Medical Association amend AMA Bylaw 7.5.2, Cessation of Eligibility, to read as follows:

7.5.2 If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.5.1 prior to the expiration of the term for which elected, they shall be permitted to complete the term of office even if they are ~~the term of such officer or member shall terminate and the position shall be declared~~

~~vacant. If any officer's or member's term would terminate prior to the conclusion of an Annual Meeting, such officer or member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which such officer or member ceases to meet the membership requirements of Bylaw 7.5.1, as long as the officer or member remains an active physician member of the AMA. The preceding provision shall not apply to the Chair-Elect.~~

~~Notwithstanding the immediately preceding provision of this section, the Immediate Past Chair shall be permitted to complete the term of office even if the Immediate Past Chair is unable to continue to meet all of the membership requirements of Bylaw 7.5.1, as long as the office remains an active physician member of the AMA. (Modify Bylaws)~~

Testimony supported the resolution. Speakers noted that it takes time to get acclimated to AMA and section procedures and prepare for leadership. Others noted that the classification of “young physician” is somewhat artificial and inconsistent across different AMA component groups. Supporters also suggested that sections should have the ability to choose their own leadership criteria, and that this change would increase eligibility for leadership participation, particularly among those with longer residency programs. Testimony opposed to the resolution noted that this would change precedence in the AMA Bylaws, and could create conflict with section IOPs. Your Reference Committee looks forward to an expeditious response from the Council on Constitution and Bylaws and resolution of any issues remaining with that Council's Report 3. Your Reference Committee recommends that Resolution 24 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (13) COUNCIL ON CONSTITUTION & BYLAWS REPORT 2 – AMA WOMEN PHYSICIANS SECTION: CLARIFICATION OF BYLAW LANGUAGE

RECOMMENDATION A:

Recommendations in Council on Constitution and Bylaws Report 2 be amended by addition and deletion to read as follows:

7.10.1 Membership. All **female** physicians and medical students who are active members of the AMA **and identify as female** shall be **eligible to be** members of the Women Physicians Section. ~~7.10.1.1~~ Other active members of the AMA who express an interest in women's issues shall be eligible to join the section. (Modify Bylaws)

RECOMMENDATION B:

Recommendations in Council on Constitution and Bylaws Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Constitution and Bylaws Report 2 referred.

The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

7.10 Women Physicians Section. The Women Physicians Section is a delineated Section.

7.10.1 Membership. All female physicians and medical students who are active members of the AMA shall be **eligible to be** members of the Women Physicians Section. ~~7.10.1.1~~ Other active members of the AMA who express an interest in women's issues shall be eligible to join the section. (Modify Bylaws)

Unanimous testimony was heard in support of the recommendations in the report. An amendment was offered to include language that encompasses all physicians who identify as female be included as members of the WPS. Your Reference Committee recommends that Council on Constitution and Bylaws Report 2 be adopted as amended.

- (14) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 – CEJA’S SUNSET REVIEW OF 2011 HOUSE POLICIES

RECOMMENDATION A:

The recommendation in Council on Ethical and Judicial Affairs Report 1 be amended by addition, with the concurrence of the Council on Ethical and Judicial Affairs, to read as follows:

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of Policy H-460.924, which should be retained, and the remainder of this report be filed. (Directive to Take Action)

RECOMMENDATION B:

That Council on Ethical and Judicial Affairs Report 1 be adopted as amended, and the remainder of this report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 1 adopted as amended, and the remainder of this report filed.

The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

The report was introduced by the authors. There was limited but unanimous testimony recommending that Policy H-460.924 “Race and Ethnicity as Variables in Medical Research” be retained. Upon reconsideration, the Council agreed, considers this to be a friendly amendment and concurs with the amendment. Therefore, your Reference Committee recommends that Council and Ethical and Judicial Affairs Report 1 be adopted as amended.

- (15) RESOLUTION 1 - DISCRIMINATION AGAINST PHYSICIANS TREATED FOR MEDICATION OPIOID USE DISORDER (MOUD)

RECOMMENDATION A:

The Second Resolve in Resolution 1 be amended by deletion to read as follows:

RESOLVED, That our AMA affirm that no physician or medical student should be presumed impaired because they and their treating physician have chosen medication for opioid use disorder (MOUD) to address the substance use disorder, including but not limited to methadone and buprenorphine (New HOD Policy); and be it further

RECOMMENDATION B:

This Third Resolve in Resolution 1 be amended by deletion to read as follows:

RESOLVED, That our AMA strongly encourage the leadership of physician health and wellness programs, state medical boards, hospital and health system credentialing bodies, and employers to help end stigma and discrimination against physicians and medical students with substance use disorders and allow and encourage the usage of medication for opioid use disorder (MOUD), including but not limited to methadone or

buprenorphine, when clinically appropriate and as determined by the physician or medical student (as patient) and their treating physician, without penalty (such as restriction of privileges, licensure, ability to prescribe medications or other treatments, or other limits on their ability to practice medicine), solely because the physician's or medical student's treatment plan includes MOUD (Directive to Take Action); and be it further

RECOMMENDATION C:

This Fourth Resolve in Resolution 1 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA survey physician health programs and state medical boards and report back about the prevalence of MOUD among physicians under monitoring for OUD, types of MAT utilized, and practice limitations or other punitive measures, if any, imposed solely on the basis of medication choice. ~~whether they allow participants/licensees to use MOUD without punishment, or exclusion from practicing medicine or having to face other adverse consequences.~~ (Directive to Take Action)

RECOMMENDATION D:

Resolution 1 be adopted as amended.

RECOMMENDATION E:

That the title of Resolution 1 be changed to read as follows:

Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders (MOUD)

HOD ACTION: Resolution 1 adopted as amended with a change in title to read as follows:

Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders (MOUD)

RESOLVED, That our American Medical Association affirm that no physician or medical student should be presumed to be impaired by substance or illness solely because they are diagnosed with a substance use disorder (New HOD Policy); and be it further

RESOLVED, That our AMA affirm that no physician or medical student should be presumed impaired because they and their treating physician have chosen medication for opioid use disorder (MOUD) to address the substance use disorder, including methadone and buprenorphine (New HOD Policy); and be it further

RESOLVED, That our AMA strongly encourage the leadership of physician health and wellness programs, state medical boards, hospital and health system credentialing bodies, and employers to help end stigma and discrimination against physicians and medical students with substance use disorders and allow and encourage the usage of medication for opioid use disorder (MOUD), including methadone or buprenorphine, when clinically appropriate and as determined by the physician or medical student (as patient) and their treating physician, without penalty (such as restriction of privileges, licensure, ability to prescribe medications or other treatments, or other limits on their ability to practice medicine), solely because the physician's or medical student's treatment plan includes MOUD (Directive to Take Action); and be it further

RESOLVED, That our AMA survey physician health programs and state medical boards and report back about whether they allow participants/licenseses to use MOUD without punishment, or exclusion from practicing medicine or having to face other adverse consequences. (Directive to Take Action)

Testimony was largely supportive of Resolution 1, noting that the resolution was in alignment with AMA policy, and that one's treatment should never be a reason for discrimination or stigma. Other supporting testimony noted that medication for addiction treatment should be treated the same as other medications, and that treatment does not mean and should not imply impairment. Amendments were offered to remove the names of specific medications, and a change in wording of the last resolve to convey a more neutral and effective survey approach to better accomplish the goals of the resolution. Your Reference Committee therefore recommends that Resolution 1 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (16) RESOLUTION 22 – MATERNAL LEVELS OF CARE STANDARDS OF PRACTICE

RECOMMENDATION:

That Policy H-245.971, “Home Deliveries” be reaffirmed in lieu of Resolution 22.

HOD ACTION: Policy H-245.971, “Home Deliveries” reaffirmed in lieu of Resolution 22

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

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 advocate for the adoption of national standards of practice by birthing centers across the country to help improve maternal health; and (5) 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. (Modify Current HOD Policy)

The Council on Legislation proposed that AMA Policy H-245.971, “Home Deliveries” in lieu of Resolution 22. The language proposed in the resolution proposes a national standard of practice for birthing centers, which runs counter to the AMA’s position on other issues regarding patient safety. Further testimony was unanimously in favor of reaffirmation of the aforementioned policy in lieu of Resolution 22, noting that the current policy accomplishes the goal of this resolution, stating “the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers.” Your Reference Committee recommends that AMA Policy H-245.971, “Home Deliveries” be reaffirmed in lieu of Resolution 22.

RECOMMENDED FOR REFERRAL

- (17) RESOLUTION 7 – NONCONSENSUAL AUDIO/VIDEO RECORDING AT MEDICAL ENCOUNTERS

RECOMMENDATION:

Resolution 7 be referred.

HOD ACTION: Resolution 7 referred

RESOLVED, That our American Medical Association encourage that any audio or video recording made during a medical encounter should require both physician and patient notification and consent. (New HOD Policy)

Testimony generally supported the goals of Resolution 7. However, a moderate level of concerns were raised regarding how this would impact various situations, including during forensic examinations where the patient may not consent but is compelled by a court to be recorded, claimants in other legal matters such as employment issues, and inconsistencies between states with regards to existing one-party versus two-party consent-to-record laws. Given the complexities of potential issues stemming from adoption but recognizing the general support for the goal of the resolution, your Reference Committee recommends that Resolution 7 be referred.

RECOMMENDED FOR FILING

- (18) BOARD OF TRUSTEES REPORT 8 – PLAN FOR CONTINUED PROGRESS TOWARD HEALTH EQUITY

RECOMMENDATION:

Board of Trustees Report 8 be filed.

HOD ACTION: Board of Trustees Report 8 filed

In accordance with Policy D-180.981, this informational report outlines the equity activities of our AMA from 3rd Quarter 2020 through the 2nd Quarter of 2021, with some projections into the 3rd Quarter of 2021.

Testimony was heard in strong support of filing Board of Trustees Report 8. It was noted that the report is informational, contains no recommendations, and that it is the second such informational report of its kind and unnecessary to refer. It was also noted that there will be numerous educational activities taking place at the Interim Meeting in November regarding the AMA's health equity efforts. Speakers also noted that the information contained within the report is timely, and that the Center for Health Equity has accomplished much this year, which should be promoted and applauded. Speakers also noted that while some of the content in the report may be sensitive, it is important for the AMA to continue in its health equity efforts unencumbered. Testimony in support of referral suggested the inclusion of a recommendation in a future draft that the Health Equity Plan be voted on by the HOD, but your Reference Committee believes that this report's filing should not be delayed since it speaks to events of historical record. Other testimony noted that it is a difficult task to define some of the terminology included in the report, and that it is necessary to learn and understand more before proceeding, to which others responded that the terms included have been well-established in social science and other literature for decades and are defined within the AMA's Health Equity Plan. Your Reference Committee recommends that Board of Trustees Report 8 be filed.

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS
Part 2: Report of the Election Task Force

RECOMMENDED FOR ADOPTION

(19) SPEAKERS' REPORT 2 – RECOMMENDATION 1

RECOMMENDATION:

That Recommendation 1 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 1 in Speakers' Report 2 adopted

Recommendation 1: Campaign memorabilia may not be distributed in the Not for Official Business (NFOB) bag. (New HOD Policy)

Recommendations 1 to 4 deal with campaign memorabilia, and few comments were heard. Your Reference Committee believes that the first four recommendations on campaign memorabilia will accomplish their intended purpose, which is to reduce the cost of campaigning. No changes were recommended for the report's recommendations 1 to 4.

(20) SPEAKERS' REPORT 2 – RECOMMENDATION 2

RECOMMENDATION:

That Recommendation 2 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 2 in Speakers' Report 2 adopted

Recommendation 2: Policy G-610.020, Rules for AMA Elections, paragraph 10 be amended by addition and deletion to read as follows:

- (10) Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. ~~Campaign gifts can be distributed only at the Annual Meeting in the non-official business bag and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to delegates and alternate delegates in advance of the meeting. The Speaker of the House of Delegates shall establish a limit on allowable expenditures for campaign-related gifts. In addition to these giveaway gifts, campaign memorabilia are allowed but are limited to a button, pin, or sticker. No other~~ Campaign memorabilia and giveaways that include a candidate's name or likeness may not ~~shall~~ be distributed at any time; (Modify Current HOD Policy)

Recommendation 2 drew no specific comments. Your Reference Committee believes that the recommendations on campaign memorabilia will accomplish their intended purpose, which is to reduce the cost of campaigning, and recommends adoption.

(21) SPEAKERS' REPORT 2 – RECOMMENDATION 3

RECOMMENDATION:

That Recommendation 3 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 3 in Speakers' Report 2 adopted

Recommendation 3: Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and

distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed. (New HOD Policy)

A comment was heard regarding memories that may stem from the distribution of campaign materials, but your Reference Committee does not believe the loss of stickers, pins, or buttons will adversely affect these fond memories, and greater value is found in reducing costs.

(22) SPEAKERS' REPORT 2 – RECOMMENDATION 4

RECOMMENDATION:

That Recommendation 4 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 4 in Speakers' Report 2 adopted

Recommendation 4: Policy G-610.020, Rules for AMA Elections, paragraph 8 be amended by deletion to read as follows:

- (8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, ~~or (c) distributing stickers, buttons, etc. with the candidate's name on them.~~ At these events, alcohol may be served only on a cash or no-host bar basis; (Modify Current HOD Policy)

Recommendation 4 is an additional means to limit the cost of campaigns, and again few comments were heard, either in the hearing or online. The Election Task Force made a good case for reducing costs by doing away with items found to be of small value to delegates, even though the cost per delegate was relatively low. No changes were recommended for this recommendation.

(23) SPEAKERS' REPORT 2 – RECOMMENDATION 5

RECOMMENDATION:

That Recommendation 5 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 5 in Speakers' Report 2 adopted

Recommendation 5: Our AMA will investigate the feasibility of a two- (2) year trial of sponsoring a welcome reception open to all candidates and all meeting attendees. Any candidate may elect to be “featured” at the AMA reception. There will not be a receiving line at the AMA reception. Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception (the AMA reception or another) would remain. The Speakers will report back to the House after the two year trial with a recommendation for possible continuation of the AMA reception. (New HOD Policy)

Recommendations 5 through 8 address campaign receptions, dinners, and suites. Some concern was expressed that Recommendation 5 setting up an AMA-sponsored reception would lead to a two-tiered system in which some societies or caucuses would be able to afford their own reception but other societies—those with fewer financial resources—would be relegated to the AMA reception. The survey of the House, presented as an appendix to the report, suggested delegates would attend an AMA reception. This reception provides an opportunity for social gathering for members of our House to meet candidates outside the formal interview process. In addition, the Board of Trustees is to investigate the feasibility of such a reception; it is not mandated. Insofar as this idea is proposed as a test, your Reference Committee believes the recommendation should be adopted, particularly as no society is prohibited under this policy from holding its own reception.

(24) SPEAKERS' REPORT 2 – RECOMMENDATION 6

RECOMMENDATION:

That Recommendation 6 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 6 in Speakers' Report 2 adopted

Recommendation 6: Policy G-610.020, Rules for AMA Elections, paragraph 8 be reaffirmed (minus phrase “c” recommended for deletion above):

- (8) A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, (b) appearing by name or in a picture on a poster or notice in or outside of the party venue, ~~or (c) distributing stickers, buttons, etc. with the candidate's name on them.~~ At these events, alcohol may be served only on a cash or no-host bar basis; (Reaffirm HOD Policy)

The purpose of this recommendation is to make the policy on parties and receptions consistent with the earlier recommendation to do away with pins, buttons, and stickers. As no testimony was heard, your Reference Committee infers support and recommends adoption.

(25) SPEAKERS' REPORT 2 – RECOMMENDATION 7

RECOMMENDATION:

That Recommendation 7 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 6 in Speakers' Report 2 adopted

Recommendation 7: Group dinners, if attended by an announced candidate in a currently contested election, must be “Dutch treat” - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule. (New HOD Policy)

No testimony was offered on this item in the hearing, although two comments in the online forum proposed changes regarding the number of guests (four) allowed under the exception. If the goal is to limit campaign costs, the recommendation appears reasonable as written, and your Reference Committee recommends adoption.

(26) SPEAKERS' REPORT 2 – RECOMMENDATION 8

RECOMMENDATION:

That Recommendation 8 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 8 in Speakers' Report 2 adopted

Recommendation 8: Policy G-610.020, Rules for AMA Elections, paragraph 6 be amended by addition and deletion to read as follows:

- (6) ~~At any AMA meeting convened prior to the time period for active campaigning the Interim Meeting,~~ campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited ~~at the Interim Meeting.~~ It is permissible ~~at the Interim Meeting~~ for candidates seeking election to engage in individual outreach, ~~such as small group meetings, including informal dinners,~~ meant to familiarize others with a candidate's opinions and positions on issues; (Modify Current HOD Policy)

Again, no specific comments were received on this item. Your Reference Committee believes this recommendation matches up nicely with the preceding recommendation and recommends its adoption.

(27) SPEAKERS' REPORT 2 – RECOMMENDATION 9

RECOMMENDATION:

That Recommendation 9 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 9 in Speakers' Report 2 adopted

Recommendation 9: Campaign materials may not be distributed by postal mail or its equivalent. The AMA Office of House of Delegates Affairs will no longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials. (New HOD Policy)

The Election Task Force found that few delegates find campaign literature useful, and our own experience suggests much of it is left behind, on the floor or in recycling bins. No specific comments were heard on this recommendation. It is a clear cost saving measure with ecological benefits, and your Reference Committee recommends adoption.

(28) SPEAKERS' REPORT 2 – RECOMMENDATION 10

RECOMMENDATION:

That Recommendation 10 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 10 in Speakers' Report 2 adopted

Recommendation 10: Policy G-610.020, Rules for AMA Elections, paragraph 9 be amended by addition and deletion to read as follows:

- (9) Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured parties, and campaign literature may be distributed in the non-official business bag for members of the House of Delegates. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates; (Modify Current HOD Policy)

An amendment was suggested for Recommendation 10 to add a specific reference to holiday cards, but if these or any other item are mailed to a substantial portion of the House, they would be prohibited under other recommendations and even current policy. Otherwise, the proposal appears to be uniformly supported, with adoption recommended by the reference committee.

(29) SPEAKERS' REPORT 2 – RECOMMENDATION 11

RECOMMENDATION:

That Recommendation 11 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 11 in Speakers' Report 2 adopted

Recommendation 11: The AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD

Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates. (New HOD Policy)

While no one commented on this recommendation, your Reference Committee notes that the House of Delegates has provided the service called for in the recommendation and has done so without creating problems for recipients. Your Reference Committee supports adoption.

(30) SPEAKERS' REPORT 2 – RECOMMENDATION 12

RECOMMENDATION:

That Recommendation 12 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 12 in Speakers' Report 2 adopted

Recommendation 12: Policy G-610.020, Rules for AMA Elections, paragraph 5 be amended by addition and deletion to read as follows:

- (5) A reduction in the volume of telephone calls and electronic communication from candidates, ~~and literature and letters by or~~ and on behalf of candidates is encouraged. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages; (Modify Current HOD Policy)

One online comment questioned whether the “simple” opt out mechanism noted in Recommendation 12 exists, but your Reference Committee believes the recommendation merits adoption, as the onus ought not be on message recipients but on those sending electronic messages. Moreover, this is nothing more than modernization (electronic communication) and clarification of existing policy. Adoption is warranted.

(31) SPEAKERS' REPORT 2 – RECOMMENDATION 13

RECOMMENDATION:

That Recommendation 13 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 13 in Speakers' Report 2 adopted

Recommendation 13: An AMA Candidates' Page will be created on the AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates. (New HOD Policy)

Absent any negative commentary, this recommendation is an excellent service for our members and is another innovative way to limit costs. It also supports distribution of campaign information on an equal platform for all candidates. Your Reference Committee recommends adoption.

(32) SPEAKERS' REPORT 2 – RECOMMENDATION 14

RECOMMENDATION:

That Recommendation 14 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 14 in Speakers' Report 2 adopted

Recommendation 14: Policy G-610.020, Rules for AMA Elections, paragraph 4 be amended by addition to read as follows:

- (4) An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates; (Modify Current HOD Policy)

No comments specific to this item were heard. The recommendation makes this item consistent with the preceding recommendation, and adoption is recommended. One stated goal of the Task Force was to level campaign opportunities for all candidates regardless of resources. Your Reference Committee believes this recommendation will move toward that goal.

- (33) SPEAKERS' REPORT 2 – RECOMMENDATION 15

RECOMMENDATION:

That Recommendation 15 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 15 in Speakers' Report 2 adopted

Recommendation 15: Policy G-610.020, Rules for AMA Elections, paragraph 14 be reaffirmed:

- (14) Every state and specialty society delegation is encouraged to participate in a regional caucus, for the purposes of candidate review activities; and (Reaffirm HOD Policy)

Having heard no comments on this recommendation, your Reference Committee recommends adoption of this recommendation as it is a straight reaffirmation of current policy.

- (34) SPEAKERS' REPORT 2 – RECOMMENDATION 17

RECOMMENDATION:

That Recommendation 17 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 17 in Speakers' Report 2 adopted

Recommendation 17: The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website. (New HOD Policy)

Although one item in this group of recommendations related to interviews caused some concern, this recommendation did not. Your Reference Committee recommends adoption, and we would note that the Speakers have received positive commentary on their efforts.

- (35) SPEAKERS' REPORT 2 – RECOMMENDATION 18

RECOMMENDATION:

That Recommendation 18 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 18 in Speakers' Report 2 adopted

Recommendation 18: Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker. (New HOD Policy)

The report's recommendations on the voting process garnered few comments and are recommended for adoption. A concern about ensuring that only delegates would be able to vote was expressed, but the Vice Speaker described security arrangements that are available and planned for use. Chief among these is the use of a special card that will be given only to delegates and that is necessary to cast a vote using the electronic devices. Your Reference Committee believes that security considerations are paramount but is confident that the Speakers and chief teller, who manages the actual election, will address security. We have independently learned that the planned system is widely used and complies with strict European requirements for security and privacy.

(36) SPEAKERS' REPORT 2 – RECOMMENDATION 19

RECOMMENDATION:

That Recommendation 19 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 19 in Speakers' Report 2 adopted

Recommendation 19: Policy G-610.030, Election Process be amended by addition and deletion to read as follows:

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; (2) ~~Poll hours will not be extended beyond the times posted.~~ All delegates eligible to vote must be seated within the House in line to vote at the time appointed to cast their electronic votes, ~~for the close of polls~~; and (3) The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House. (Modify Current HOD Policy)

The primary purpose of this recommendation is to update our election process, utilizing available electronic voting technology and ensure internal consistency among the recommendations. Your Reference Committee recommends adoption, having heard no concerns expressed either online or in the hearing.

(37) SPEAKERS' REPORT 2 – RECOMMENDATION 20

RECOMMENDATION:

That Recommendation 20 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 20 in Speakers' Report 2 adopted

Recommendation 20: The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments. (New HOD Policy)

One commenter online suggested that your Speakers might project thank you notes from candidates, much as is done with candidate announcements. No objections have been lodged regarding this process, which has been used for our last two meetings. The Reference Committee also notes that this is merely a suggestion to the Speaker, giving the Speaker flexibility to implement as needed. Your Reference Committee recommends adoption.

(38) SPEAKERS' REPORT 2 – RECOMMENDATION 21

RECOMMENDATION:

That Recommendation 21 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 21 in Speakers' Report 2 adopted

Recommendation 21: Policy G-610.020, Rules for AMA Elections, paragraph 2 be amended by addition to read as follows:

(2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, URL, the office sought and a list of endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed in the venue where the House of Delegates meets. Announcements sent by candidates to members of the House are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election; (Modify Current HOD Policy)

Announcements and nominations are the subject of Recommendations 21 to 26. Only a comment or two were offered on these nominations during the hearing; no comments were posted online. No negative comments were offered. This recommendation closes a loophole in the current rules against mass outreach to the House of Delegates before the allowed active campaign period. Your Reference Committee recommends adoption.

(39) SPEAKERS' REPORT 2 – RECOMMENDATION 22

RECOMMENDATION:

That Recommendation 22 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 22 in Speakers' Report 2 adopted

Recommendation 22: Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out following the April Board meeting and on "Official Announcement Dates" to be established by the Speaker. (New HOD Policy)

Only a comment or two were offered on these recommendations during the hearing, and no comments were posted online. Your Reference Committee considers these recommendations to be clarifications of our announcement process and recommends adoption.

(40) SPEAKERS' REPORT 2 – RECOMMENDATION 23

RECOMMENDATION:

That Recommendation 23 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 23 in Speakers' Report 2 adopted

Recommendation 23: Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on any council or the Board of Trustees, at any time by submitting an announcement card and their conflict of interest statement to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications" and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Announcement Date. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than at the specified times. (New HOD Policy)

There was no testimony on this recommendation, which clarifies that independent announcements by candidates may be distributed after active campaigning is allowed. This provides the opportunity for a candidate who wishes to independently announce, but only during active campaigning. This recommendation from the preceding two recommendations. Consequently, your Reference Committee recommends adoption of these recommendations.

(41) SPEAKERS' REPORT 2 – RECOMMENDATION 24

RECOMMENDATION:

That Recommendation 24 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 24 in Speakers' Report 2 adopted

Recommendation 24: Policy G-610.020, Rules for AMA Elections, paragraph 15 be reaffirmed:

- (15) Our AMA (a) requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election; and (b) will expand accessibility to completed conflict of interest information by posting such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents. (Reaffirm HOD Policy)

No comments were received. This is a reaffirmation of policy and should be adopted.

(42) SPEAKERS' REPORT 2 – RECOMMENDATION 25

RECOMMENDATION:

That Recommendation 25 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 25 in Speakers' Report 2 adopted

Recommendation 25: Policy G-610.010, Nominations be amended by addition and deletion to read as follows:

Guidelines for nominations for AMA elected offices include the following: (1) every effort should be made to nominate two or more eligible members for each Council vacancy; (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity; (3) the date for submission of ~~nominations to~~ applications for consideration by the Board of Trustees at its April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year; (4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only; (Modify Current HOD Policy)

This recommendation is meant to clarify and more accurately state language regarding nominations and the paperwork that is submitted to the Board of Trustees for its review of council candidates. It should be adopted.

(43) SPEAKERS' REPORT 2 – RECOMMENDATION 26

RECOMMENDATION:

That Recommendation 26 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 26 in Speakers' Report 2 adopted

Recommendation 26: Policy G-610.020, Rules for AMA Elections, paragraph 3, be amended by addition and deletion to read as follows:

- (3) Active campaigning for AMA elective office may not begin until the Board of Trustees, after its April meeting, announces the ~~nominees~~ candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on

behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates; (Modify Current HOD Policy)

This recommendation too clarifies language to make it more accurate. Nominations occur at the opening session of the House. The Board simply announces the candidates after its April meeting. This recommendation should be adopted.

(44) SPEAKERS' REPORT 2 – RECOMMENDATION 27

RECOMMENDATION:

That Recommendation 27 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 27 in Speakers' Report 2 adopted

Recommendation 27: The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions. (New HOD Policy)

Delegates have expressed the view that interviews are the best tool for gaining knowledge about a candidate, but they also express concern about their ability to properly vet candidates who “pop up” as a result of a prior election, as there is no time to assess the candidate’s qualifications. This recommendation, along with Recommendations 28 to 31, is an effort to address that concern. The approach that would derive from Recommendations 27 to 31 is not perfect, but no solution considered by the Task Force (see the Appendix to their report) was thought to be perfect. As this series of recommendations will be reviewed in two years, your Reference Committee recommends adoption. This specific recommendation provides for communication of potential newly opened positions to the entire House, alerting potential candidates. This recommendation adds transparency to the process.

(45) SPEAKERS' REPORT 2 – RECOMMENDATION 28

RECOMMENDATION:

That Recommendation 28 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 28 in Speakers' Report 2 adopted

Recommendation 28: If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. (New HOD Policy)

This recommendation provides logistics for what occurs in the event that newly opened positions do not arise, making it clear that no election for the position will occur. Your Reference Committee recommends adoption.

(46) SPEAKERS' REPORT 2 – RECOMMENDATION 29

RECOMMENDATION:

That Recommendation 29 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 29 in Speakers' Report 2 adopted

Recommendation 29: If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. (New HOD Policy)

This recommendation is further clarification of logistical concerns. It eliminates some concern of delegations considering supporting more than one candidate for a given office in the event that a newly opened position arises, and makes clear that if this position does not arise, that candidates who were running for the potential seat would be given the opportunity to withdraw prior to the vote. Your Reference Committee recommends adoption.

(47) SPEAKERS' REPORT 2 – RECOMMENDATION 30

RECOMMENDATION:

That Recommendation 30 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 30 in Speakers' Report 2 adopted

Recommendation 30: In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled position/s would remain unfilled until the next annual meeting. (New HOD Policy)

Some unease was expressed about this recommendation, with the idea that vacancies might exist on a council for a year being of concern. Given the advance communication of potential open seats specified in preceding recommendations, your Reference Committee believes this will be a very rare event. In addition, the concern regarding this recommendation seems to pale in comparison to another possibility that was considered that would leave all newly opened seats unfilled until the next meeting. This is outlined in the report's appendix. Adoption is the recommendation of your Reference Committee.

(48) SPEAKERS' REPORT 2 – RECOMMENDATION 31

RECOMMENDATION:

That Recommendation 31 in Speakers' Report 2 be adopted.

HOD ACTION: Recommendation 31 in Speakers' Report 2 adopted

Recommendation 31: Bylaws 3.4.2.2 and 6.8.1.5 be rescinded.

3.4.2.2 At-Large Trustees to be Elected to Fill Vacancies after a Prior Ballot. The nomination and election of Trustees to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other Trustees and shall follow the same procedure. Individuals so elected shall be elected to a complete 4-year term of office. Unsuccessful candidates in any election for Trustee, other than the young physician trustee and the resident/fellow physician trustee, shall automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted.

6.8.1.5 Council Members to be Elected to Fill Vacancies after a Prior Ballot. The nomination and election of members of the Council to fill a vacancy that did not exist at the time of the prior ballot shall be held after election of other members of the Council, and shall follow the same procedure. Individuals elected to such vacancy shall be elected to a complete 4-year term. Unsuccessful candidates in the election for members of the Council shall automatically be nominated for subsequent elections to fill any such vacancy until all members of the Council have been elected. In addition, nominations from the floor shall be accepted. (Modify Bylaws)

There was no testimony on this recommendation and your Reference Committee recommends adoption. Your Reference Committee believes that it is not necessary to accomplish the recommended Bylaws change prior to the November meeting when this change can be presented in a report from the Council on Constitution and Bylaws.

(49) SPEAKERS' REPORT 2 – RECOMMENDATION 33

RECOMMENDATION:**That Recommendation 33 in Speakers' Report 2 be adopted.****HOD ACTION: Recommendation 33 in Speakers' Report 2 adopted**

Recommendation 33: Policy G-610.021, Guiding Principles for House Elections, principle 2 be amended by addition to read as follows:

- (2) Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations. (Modify Current HOD Policy)

This recommendation clarifies an existing principle. Recommendations 33 and 34 received but one online comment between them, so your Reference Committee recommends that they be adopted.

(50) SPEAKERS' REPORT 2 – RECOMMENDATION 34

RECOMMENDATION:**That Recommendation 34 in Speakers' Report 2 be adopted.****HOD ACTION: Recommendation 34 in Speakers' Report 2 adopted**

Recommendation 34: Policy G-610.021, Guiding Principles for House Elections, principles 1, 3, 4, 5 and 6 be reaffirmed:

- (1) AMA delegates should: (a) avail themselves of all available background information about candidates for elected positions in the AMA; (b) determine which candidates are best qualified to help the AMA achieve its mission; and (c) make independent decisions about which candidates to vote for.
- (3) Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
- (4) Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for AMA leadership positions.
- (5) Incumbency should not assure the re-election of an individual to an AMA leadership position.
- (6) Service in any AMA leadership position should not assure ascendancy to another leadership position. (Reaffirm HOD Policy)

This recommendation is a straightforward reaffirmation. It should be adopted.

(51) SPEAKERS' REPORT 2 – RECOMMENDATION 36

RECOMMENDATION:**That Recommendation 36 in Speakers' Report 2 be adopted.****HOD ACTION: Recommendation 36 in Speakers' Report 2 adopted**

Recommendation 36: Policy G-610.021, Guiding Principles for House Elections, be amended by addition of an additional principle 8 to read as follows:

- (8) Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.
(Modify Current HOD Policy)

No concerns were expressed about this recommendation. As a guiding principle for elections, it is in the best interests of the profession and our Association to select the “most qualified individuals for our AMA.” Your Reference Committee recommends adoption.

- (52) SPEAKERS’ REPORT 2 – RECOMMENDATION 37

RECOMMENDATION:

That Recommendation 37 in Speakers’ Report 2 be adopted.

HOD ACTION: Recommendation 37 in Speakers’ Report 2 adopted

Recommendation 37: Policy G-610.030, Election Process, paragraph 1 be reaffirmed:

AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at each Annual Meeting; ... (Reaffirm HOD Policy)

Recommendation 37 regarding “the day of the elections” received a positive comment from the Task Force, with nothing further received. Your Reference Committee recommends adoption. The appendix in the report details the consideration of the Task Force that led to the conclusion that our current schedule for elections on Tuesday should continue.

- (53) SPEAKERS’ REPORT 2 – RECOMMENDATION 38

RECOMMENDATION:

That Recommendation 38 in Speakers’ Report 2 be adopted.

HOD ACTION: Recommendation 38 in Speakers’ Report 2 adopted

Recommendation 38: In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. (New HOD Policy)

Only one comment was provided during the hearing and it favored establishing the recommended election committee. A suggestion was made online to consider using former officers of the AMA on the election committee, which the Speakers may wish to consider. In the absence of concerns about such a committee, your Reference Committee recommends adoption of these recommendations and encourages the Speakers to make any decisions rendered by the election committee known to the House either by announcement from the dais or by a Speakers’ Report, depending on the urgency of the matter.

(54) SPEAKERS' REPORT 2 – RECOMMENDATION 39

RECOMMENDATION:**That Recommendation 39 in Speakers' Report 2 be adopted.****HOD ACTION: Recommendation 39 in Speakers' Report 2 adopted**

Recommendation 39: The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties This process will be presented to the House for approval. (New HOD Policy)

There were no concerns were expressed in the hearing or online regarding this recommendation, which calls for communication back to the House regarding the proposed process. Your Reference Committee recommends adoption to facilitate the establishment of a functional election committee.

(55) SPEAKERS' REPORT 2 – RECOMMENDATION 40

RECOMMENDATION:**That Recommendation 40 in Speakers' Report 2 be adopted.****HOD ACTION: Recommendation 40 in Speakers' Report 2 adopted**

Recommendation 40: Policy G-610.020, Rules for AMA Elections, paragraph 1 be amended by addition to read as follows:

- (1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules; (Modify Current HOD Policy)

This recommendation, a modest change to existing policy, will enable the Speaker to work with the election committee that would be established by preceding recommendations. Your Reference Committee recommends adoption.

(56) SPEAKERS' REPORT 2 – RECOMMENDATION 41

RECOMMENDATION:**That Recommendation 41 in Speakers' Report 2 be adopted and the remainder of the report filed.****HOD ACTION: Recommendation 41 in Speakers' Report 2 adopted and the remainder of the report filed**

Recommendation 41: After an interval of 2 years a review of our election process, including the adopted recommendations from this report, be conducted by the Speaker and, at the Speaker's discretion the appointment of another election task force, with a report back to the House. (New HOD Policy)

With respect to Recommendation 41, calling for a review of any changes two years hence, no objections were heard. A member of the Task Force commented that they believe their recommendations will provide improvements over the current process, but the House will have an opportunity to review any changes. Your Reference Committee recommends adoption.

RECOMMENDED FOR ADOPTION AS AMENDED(57) **SPEAKERS' REPORT 2 – RECOMMENDATION 35****RECOMMENDATION A:**

That Recommendation 35 in Speakers' Report 2 be amended by deletion to read as follows:

Policy G-610.021, Guiding Principles for House Elections, be amended by addition of an additional principle 7 to read as follows:

- (7) Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates ~~but should refrain from rank order lists of candidates.~~ (Modify Current HOD Policy)

RECOMMENDATION B:

That Recommendation 35 in Speakers' Report 2 be adopted as amended.

HOD ACTION: Recommendation 35 in Speakers' Report 2 adopted as amended.

Recommendation 35: Policy G-610.021, Guiding Principles for House Elections, be amended by addition of an additional principle 7 to read as follows:

- (7) Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates but should refrain from rank order lists of candidates. (Modify Current HOD Policy)

Your Reference Committee heard concern that this recommendation constituted an overreach by our AMA and that delegations should be able to determine their own processes. That said, other testimony supported open discussion of the qualifications of candidates. Your Reference Committee therefore recommends deletion of the portion of the recommendation that drew concern.

RECOMMENDED FOR REFERRAL(58) **SPEAKERS' REPORT 2 – RECOMMENDATION 16****RECOMMENDATION:**

That Recommendation 16 in Speakers' Report 2 be referred.

HOD ACTION: Recommendation 16 in Speakers' Report 2 referred

Recommendation 16: Delegations and caucuses may conduct interviews by virtual means in advance of the Annual Meeting of the House of Delegates during a period of time to be determined by the Speaker in lieu of in-person interviews at the meeting. Delegations and caucuses may choose either method, but not both for a given race. Groups electing to interview candidates for a given position must provide an equal opportunity for all candidates for that position who have announced their intention to be nominated at the time interviews are scheduled, to be interviewed using the same format and platform. An exception being that a group may elect to meet with a candidate who is from their own delegation without interviewing other candidates. Recording of virtual interviews must be disclosed to candidates prior to recording and may only be recorded with candidate consent. Interview recordings may only be shared with members of the interviewing caucus/group. (New HOD Policy)

This recommendation led to considerable discussion. While there was general support for virtual interviews, among both candidates and interviewers who had experienced virtual interviews in 2020 and this year, there was a desire to

ensure that interviews do not interfere with clinical time and are conducted within a defined, limited and reasonable timeframe before the Annual Meeting convenes. Your Reference Committee believes that there is value in continuing virtual interviews but agrees there are further details to work out. Therefore, your Reference Committee recommends referral for study, with the expectation that the report will come to the 2021 Interim Meeting.

RECOMMENDED FOR NOT-ADOPTION

(59) SPEAKERS' REPORT 2 – RECOMMENDATION 32

RECOMMENDATION:

That Recommendation 32 in Speakers' Report 2 not be adopted.

HOD ACTION: Recommendation 32 in Speakers' Report 2 not adopted.

Recommendation 32: Members of the Council on Constitution & Bylaws (CC&B) will be appointed. The appointment process would include consideration by the Board of Trustees of nominated candidates with a slate for each open position presented to the House of Delegates for approval. Terms, tenure and role of the council would remain unchanged. Appropriate bylaws to accomplish this change will be crafted by CC&B. (Modify Bylaws)

Recommendation 32, calling for the appointment of members to the Council on Constitution and Bylaws, was largely opposed by those who testified. Your Reference Committee has recommended non-adoption for this recommendation.

REPORT OF REFERENCE COMMITTEE A

RECOMMENDED FOR ADOPTION

- (1) COUNCIL ON MEDICAL SERVICE REPORT 2 – CONTINUITY OF CARE FOR PATIENTS DISCHARGED FROM HOSPITAL SETTINGS

RECOMMENDATION:

Recommendations in Council on Medical Service Report 2 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 2 adopted and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of the second resolve of amended Resolution 212-A-19, and the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge. (New HOD Policy)
2. That our AMA support medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient’s health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge. (New HOD Policy)
3. That our AMA support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients. (New HOD Policy)
4. That our AMA advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors. (New HOD Policy)
5. That our AMA advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTBP) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy)
6. That our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTBP tools. (New HOD Policy)
7. That our AMA reaffirm Policy H-125.979, which directs the AMA to work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers. (Reaffirm HOD Policy)

Your Reference Committee heard testimony that was supportive of Council on Medical Service Report 2. A member of the Council on Medical Service introduced the report by noting that the Council reviewed a variety of strategies used by hospitals to ensure continuity of care after discharge, including medication reconciliation prior to discharge and programs that provide transitional supplies of discharge medications to patients. Testimony from the Council and others highlighted real-time pharmacy benefit tools as especially promising for improving continuity of care during the discharge period given that problems ensuring coverage of discharge medications can hold up hospital discharge. Your Reference Committee believes a minor amendment to add “prior to discharge” to Recommendation 2 is unnecessary since the recommendation already includes the language “prior to hospital discharge.” Accordingly,

your Reference Committee recommends that the recommendations of Council on Medical Service Report 2 be adopted.

- (2) COUNCIL ON MEDICAL SERVICE REPORT 8 – LICENSURE AND TELEHEALTH

RECOMMENDATION:

Recommendations in Council on Medical Service Report 8 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation 1 in Council on Medical Service Report 8 referred for decision. The rest of the recommendations in Council on Medical Service Report 8 adopted and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-20, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) work with the Federation of State Medical Boards, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met:

- a) The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action.
- b) There is a pre-existing and ongoing physician-patient relationship.
- c) The physician has had an in-person visit(s) with the patient.
- d) The telehealth services are incident to an existing care plan or one that is being modified.
- e) The physician maintains liability coverage for telehealth services provided to patients in states other than the state where the physician is licensed.
- f) Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules. (Directive to Take Action)

2. That our AMA amend Policy H-480.969[1] by addition and deletion as follows:

The Promotion of Quality Telemedicine H-480.969

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

- (a) ~~application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state;~~
- (~~b~~a) exemption from such a licensure requirement for ~~traditional informal~~ physician-to-physician consultations (“~~curbside consultations~~”) that are provided without expectation of compensation;
- (~~e~~b) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
- (c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.
- (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (Modify Current AMA Policy)

3. That our AMA continue to support state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946, Coverage and Payment for Telemedicine. (New HOD Policy)

4. That our AMA reaffirm Policy D-480.964, which directs the AMA to work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact; advocate for reduced application and state licensure(s) fees processed through the Interstate Medical Licensure Compact; and work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state's medical board. (Reaffirm HOD Policy)

Testimony was generally supportive of Council on Medical Service Report 8. A member of the Council on Medical Service introduced the report by emphasizing that this is the Council's second report on licensure and telehealth in as many years. As highlighted by the Council member, the report seeks to strike the right balance between strengthening telehealth options while protecting patients and physician-patient relationships. A member of the Council on Legislation testified in support of the report and its recommendations that encourage interstate telehealth while also recognizing the important roles of states, state medical boards, and the Interstate Medical Licensure Compact.

In response to a proposed amendment to add "practice" after "physician" to Recommendation 1(b) and (c), a Council on Medical Service member explained that the Council had focused its deliberations on the importance of maintaining established physician-patient relationships and therefore chose to use the term "physician-patient" instead of "practice-patient" to describe that relationship. The Council member stressed that the proposed amendment could open a loophole to corporate providers. It was also noted by the Council member that a physician who is covering another physician acts as that physician's proxy in the physician-patient relationship and that a change to the recommendation is not needed.

A Council on Medical Service member also testified against an amendment recommending that the AMA explore opportunities for expanding telehealth to include out-of-state physicians' use of telehealth to provide initial consultation for care that may not be available in the patient's home state. The Council member emphasized that using telehealth to provide care to patients across state lines where there is not an established physician-patient relationship would require additional scrutiny. Your Reference Committee believes that while this may be an issue worthy of further study, this amendment may be beyond the current report's focus on interstate telehealth for continuity of care where there are established physician-patient relationships.

Your Reference Committee also heard sufficient concerns regarding the proposed amendment to add "practice" to Recommendation 1(b) and (c) and therefore does not recommend that change. In response to a speaker's concern that Recommendation 1(d) would preclude using telehealth to treat an established patient who is seeking care for a new condition, your Reference Committee believes that the recommendation as written is sufficient because it specifies that care can be incident to an existing care plan or one that is being modified. Because a preponderance of the testimony supported the report recommendations as written, your Reference Committee recommends that the Council on Medical Service Report 8 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (3) COUNCIL ON MEDICAL SERVICE REPORT 7 – ADDRESSING EQUITY IN TELEHEALTH

RECOMMENDATION A:

Recommendation 7 in Council on Medical Service Report 7 be amended by addition to read as follows:

7. That our AMA encourage hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth. (New HOD Policy)

RECOMMENDATION B:

Recommendation 8 in Council on Medical Service Report 7 be amended by addition and deletion to read as follows:

8. That our AMA support expanding physician practice eligibility for programs that assist ~~providers~~ qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations. (New HOD Policy)

RECOMMENDATION C:

Recommendation 12 in Council on Medical Service Report 7 be amended by addition and deletion to read as follows:

12. That our AMA advocate that physician payments ~~should consider the resource costs required to provide all physician visits and payments~~ should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. (New HOD Policy)

RECOMMENDATION D:

Council on Medical Service Report 7 be amended by addition of a new Recommendation to read as follows:

That our AMA recognize access to broadband internet as a social determinant of health. (New HOD Policy)

RECOMMENDATION E:

Recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 7 adopted as amended and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-480.963, which advocates for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-478.980, which advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States. (Reaffirm HOD Policy)

3. That our AMA encourage initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations. (New HOD Policy)
4. That our AMA encourage telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations. (New HOD Policy)
5. That our AMA support efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities. (New HOD Policy)
6. That our AMA reaffirm Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services. (Reaffirm HOD Policy)
7. That our AMA encourage hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth. (New HOD Policy)
8. That our AMA support expanding physician practice eligibility for programs that assist providers in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations. (New HOD Policy)
9. That our AMA reaffirm Policy D-480.969, which advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers. (Reaffirm HOD Policy)
10. That our AMA support efforts to ensure payers allow all contracted physicians to provide care via telehealth. (New HOD Policy)
11. That our AMA oppose efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians. (New HOD Policy)
12. That our AMA advocate that payments should consider the resource costs required to provide all physician visits and payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. (New HOD Policy)

There was highly supportive testimony on Council on Medical Service Report 7. In introducing the report, the chair of the Council on Medical Service stated that the report recommendations underscore that ownership of devices and access to the internet are beneficial for telehealth only if patients know how to use the devices and if those solutions are designed with and for patients with varying digital literacy levels and health care needs to participate in two-way audio-video telehealth. Significantly, the chair of the Council on Medical Service stressed that it is essential for physicians to serve as leading partners in efforts to improve the access of historically marginalized and minoritized communities to telehealth services.

A member of the Council on Legislation, testifying in support of the report, highlighted that the AMA has been a leader in advocating for expanded access to telehealth services for Americans because it has the capacity to improve access to care for many historically marginalized and minoritized populations and improve outcomes for at-risk patients, particularly those with chronic diseases and/or functional impairments. In conjunction with expanded access to telehealth services, the AMA has supported Congressional efforts to expand high-speed broadband internet access to underserved communities and increase digital literacy education efforts. The member of the Council on

Legislation stated that the report recommendations recognize how AMA advocacy must move forward in the telehealth space.

Minor amendments were offered to the seventh and eighth recommendations of the report to clarify the distinction between physicians and other health care providers. Your Reference Committee accepted the offered amendment to the seventh recommendation, but presents alternate amendment language for the eighth recommendation, to accurately reflect the entities currently eligible for the programs referenced in the recommendation, which range from county health departments to rural health clinics.

In addition, there was a proposed amendment to delete the reference to the consideration of resource costs in the twelfth recommendation of the report. Concerns were raised that the inclusion of the reference to resource costs in this recommendation may adversely impact efforts to ensure adequate payment for audio-only visits. There was opposition to this amendment, underscoring that consideration of resource costs aligns with the methodology of the RVS Update Committee (RUC) in ensuring credible, appropriate, and accurate recommendations to the Centers for Medicare and Medicaid Services (CMS). Testimony noted that an in-person visit includes medical supplies and specific in-person nurse tasks and time that may not be utilized in an audio-only visit. In addition, testimony highlighted that appropriate resource consideration is a long-standing precedent within the Medicare Physician Payment Schedule and important to CMS and policymakers. Ultimately, your Reference Committee accepted the amendment, as the original wording of the twelfth recommendation could have unintended impacts on advocacy efforts on the state and federal levels pertaining to equitable telehealth payment and payment for audio-only visits.

Another amendment was offered to recognize broadband access as a social determinant of health, which your Reference Committee found timely and extremely complementary to the recommendations of this report. Your Reference Committee believes that the other amendments offered are addressed by existing AMA policy, including Policy D-480.963, or are topics best served by the introduction of resolutions at a future meeting.

Your Reference Committee believes that the recommendations of Council on Medical Service Report 7 should be adopted as amended. Your Reference Committee believes that this report and its recommendations are highly consistent with the AMA's recent adoption of a new, eighth enterprise value embracing equity, which states: "We center the voices of the most marginalized in shaping policies and practices toward improving the health of the nation."

(4) RESOLUTION 121 – MEDICAID DIALYSIS POLICY FOR UNDOCUMENTED PATIENTS

RECOMMENDATION A:

Resolution 121 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

Resolution 121 be adopted as amended.

HOD ACTION: Resolution 121 adopted as amended.

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

Testimony was very supportive of the intent of Resolution 121 and the need to expand dialysis coverage to undocumented patients with end stage kidney disease. Speakers noted that undocumented patients often present in emergency departments when they are acutely ill and in urgent need of dialysis and, at times, inpatient care that is significantly more costly than dialysis provided in the outpatient setting. Amended Resolve clauses were offered by both the AMA Medical Student Section and the Council on Medical Service to clarify the resolution's intent. Your Reference Committee believes that both amendments achieve the same goals, and the language proffered by the AMA Medical Student Section is clearer about the need for coverage for outpatient dialysis. Accordingly, your Reference Committee recommends that Resolution 121 be adopted as amended.

RECOMMENDED FOR REFERRAL

- (5) RESOLUTION 122 – DEVELOPING BEST PRACTICES FOR PROSPECTIVE PAYMENT MODELS

RECOMMENDATION:

Resolution 122 be referred.

HOD ACTION: Resolution 122 referred.

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

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

Testimony was generally supportive of Resolution 122 and the need for data and study of best practices regarding prospective payment models. Speakers highlighted the timeliness of Resolution 122 given the considerable challenges posed by the COVID-19 pandemic as fewer patients sought care, decreasing revenues of practices operating under fee-for-service. There was a suggestion to delete the second Resolve clause. Other amendments were offered to provide clarity about what to include in the proposed study. Speakers cited the AMA's history of embracing pluralism and the fact that payment systems are complex and may affect various medical specialties differently. Your Reference Committee heard sufficient support for referral and therefore recommends that Resolution 122 be referred.

- (6) RESOLUTION 123 – MEDICARE ELIGIBILITY AT AGE 60

RECOMMENDATION:

Resolution 123 be referred.

HOD ACTION: Resolution 123 referred, with report back at the November 2021 Meeting of the House of Delegates.

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

Your Reference Committee heard mixed testimony on Resolution 123. Supportive testimony stressed that lowering the Medicare eligibility age to 60 could serve as a pathway to cover the uninsured ages 60 to 64 and could impact patient health care costs. Testimony in support also raised the timeliness of this resolution, due to the debate in Congress surrounding budget reconciliation, and the potential advancement of this proposal alongside that which makes the American Rescue Plan changes to the ACA permanent.

However, members of the Council on Medical Service and Council on Legislation called for reaffirmation of existing AMA policy underpinning AMA's plan to cover the uninsured in lieu of this item. Notably, members of both Councils underscored that AMA's plan to cover the uninsured already includes ways to improve coverage of the uninsured in this age cohort - half of whom are eligible for ACA premium tax credits, and 20 percent of whom are eligible for Medicaid. In sum, members of both Councils stressed that individuals ages 60 to 64 are not left behind in our AMA's plan to cover the uninsured. As such, a member of the Council on Legislation testified that helping the uninsured ages 60 to 64 does not require risking the consequences of lowering the Medicare eligibility age to 60, especially when the evidence shows that doing so would only have a very modest impact on coverage, at best. A member of the Council on Medical Service highlighted a RAND study that showed that a Medicare buy-in has little to no effect on total health insurance enrollment, as more older adults enrolling in health insurance pursuant to the establishment of the buy-in is countered by additional younger adults becoming uninsured due to the proposal's impact on premiums. In addition, a Kaiser Family Foundation report found that the effect on coverage, access and affordability of lowering the Medicare eligibility age to 60 will depend on what type of premium and cost-sharing assistance is provided to newly eligible adults. Notably, the Council member raised that most individuals currently enrolled in traditional Medicare are also enrolled in a supplemental plan – a Medicare supplemental plan, through their employer, or Medicaid – to help with out-of-pocket costs.

As evidence of potential consequences of lowering the Medicare eligibility age to 60, it was highlighted that the Kaiser Family Foundation this year found that the policy to lower the age of Medicare eligibility could potentially shift 11.7 million people with employer coverage and 2.4 million with non-group coverage into Medicare. Testimony stressed that this would not only impact the payer mix of physician practices. Those who transition out of employer coverage to Medicare if the eligibility age were lowered would take their health spending with them as well. As a result, a large proportion of their health spending would fall under the federal budget, as Medicare is partially funded by general revenues. This shift from employer coverage to Medicare could exacerbate the financial challenges facing the Medicare Trust Fund.

Testimony also highlighted that the temporary ACA improvements included in the American Rescue Plan raise questions as to the ultimate impacts of lowering the Medicare eligibility age to 60. Due to the unintended consequences cited in testimony of lowering the Medicare eligibility age to 60, as well as the evolving coverage environment due to recently enacted ACA improvements, your Reference Committee recommends that Resolution 123 be referred. Your Reference Committee is hopeful that the resulting report will examine the impacts of a Medicare buy-in in addition to lowering the Medicare eligibility to 60, reflecting testimony offered on this item.

RECOMMENDED FOR REFERRAL FOR DECISION

- (7) RESOLUTION 105 – EFFECTS OF TELEHEALTH COVERAGE AND PAYMENT PARITY ON HEALTH INSURANCE PREMIUMS

RECOMMENDATION:

Resolution 105 be referred for decision.

HOD ACTION: Resolution 105 referred for decision.

RESOLVED, That our American Medical Association conduct or commission a study on the effect that telemedicine services have had on health insurance premiums, focusing on the differences between states that had telehealth payment parity provisions in effect prior to the pandemic versus those that did not, and report back at the 2021 Interim Meeting of the AMA House of Delegates. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 105. Supporters of the resolution stressed that additional data is needed to support efforts on the state level to support fair and equitable payment for telehealth. Specifically, testimony highlighted that some opposition to advocacy efforts on the state level to improve payment for telehealth is rooted in concerns regarding the impact of equitable physician payment for telehealth on health insurance premiums.

However, concerns were raised that the study called for in the resolution may not yield helpful data or the data desired by state medical associations and national medical specialty societies. Also, testimony underscored that there are numerous inputs to health insurance premiums, which may cause the specific impact of equitable payment for telehealth to be difficult to measure. Testimony also highlighted the high fiscal note of the resolution.

There were calls for referral as well as referral for decision. Notably, one of the state medical association sponsors of Resolution 105 supported referral for decision. A member of the Council on Medical Service, in calling for referral for decision, stated that further examination is warranted to ascertain what kind of investment by the AMA is necessary to assess the impact of telehealth services on health insurance premiums. In addition, the Council member stressed that our AMA needs to ensure that state medical associations, regardless of whether their states already have equitable payment provisions in place, can benefit from any data that the AMA is able to provide. A member of the Council on Legislation underscored that there is a need to make sure that state medical associations and national medical specialty societies have the right data and information as they advocate in this space. Importantly, the Council member raised the need to ensure that the AMA's role and investment in this effort is appropriate. Your Reference Committee agrees with concerns raised in testimony and recommends that Resolution 105 be referred for decision.

REPORT OF REFERENCE COMMITTEE B

RECOMMENDED FOR ADOPTION

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

RECOMMENDATION:

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

HOD ACTION: Board of Trustees Report 7 adopted and the remainder of the report filed

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

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

- (2) RESOLUTION 213 –CMMI PAYMENT REFORM MODELS

RECOMMENDATION:

Resolution 213 be adopted.

HOD ACTION: Resolution 213 adopted

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

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

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

Your Reference Committee heard how Resolution 213 addresses efforts to advocate against mandatory Centers for Medicare & Medicaid Services (CMS) Innovation Center (CMMI) demonstration projects and to further advocate for CMS to seek innovative payment and care delivery models from physician groups to help guide the work of CMMI as they propose voluntary demonstration projects that can be appropriately tested and advocate for CMMI to focus on the development of multiple pilot projects across many specialties, which are voluntary and tailored to the needs of local communities. Your Reference Committee heard that this resolution is consistent with existing AMA policy and advocates that CMS work with Physician-Focused Payment Model Technical Advisory Committee (PTAC) to guide CMMI to develop physician-designed models that could benefit Medicare and Medicaid patients. Your Reference Committee heard how our AMA 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.

HOD ACTION: Resolution 216 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.

HOD ACTION: Resolution 217 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.

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

HOD ACTION: Resolution 232 adopted as amended

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

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

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

- (6) RESOLUTION 233 –NON-PHYSICIAN TITLE MISAPPROPRIATION

RECOMMENDATION:

Resolution 233 be adopted.

HOD ACTION: Resolution 233 adopted

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

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

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

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.

HOD ACTION: Board of Trustees Report 14 adopted as amended and the remainder of the report 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 as amended in lieu of Resolution 230 and the remainder of the report be filed.

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
- (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.~~

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

RECOMMENDATION B:

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

HOD ACTION: Resolution 206 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.

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

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

RECOMMENDATION B:

Resolution 210 be adopted as amended.

HOD ACTION: Resolution 210 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.

HOD ACTION: Resolution 215 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.

HOD ACTION: Resolution 226 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 accrual 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.

HOD ACTION: Resolution 227 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.

HOD ACTION: Resolution 228 adopted as amended Policies D-440.921 and H-440.875 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.

HOD ACTION: Resolution 229 adopted as amended. Policies D-420.993, H-430.986, H-315.983, and H-60.909 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.

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

Your Reference Committee heard that the position of our AMA on the accessibility of naloxone over the counter, current policy H-95.932, Increasing Availability of Naloxone, makes clear that “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.” 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.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (17) RESOLUTION 201 –ENSURING CONTINUED ENHANCED ACCESS TO HEALTHCARE VIA TELEMEDICINE AND TELEPHONIC COMMUNICATION

RECOMMENDATION:

Alternate Resolution 201 be adopted in lieu of Resolution 201 to read as follows:

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

HOD ACTION: Alternate Resolution 201 adopted in lieu of Resolution 201

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

Your Reference Committee heard positive testimony on the spirit of Resolution 201. Your Reference Committee heard that our AMA has advocated in support of a transition period to allow providers to come into compliance with HIPAA after the end of the public health emergency without penalty. Your Reference Committee also heard that our AMA does not have established policy on whether it should advocate for a transition period at the close of the public health emergency. Your Reference Committee heard positive testimony on the importance of delaying potential audits and the need to ensure a transition period so that telehealth services can continue for patients who do not have access to HIPAA compliant platforms. Testimony was offered in support of alternate language that would further clarify our AMA's goal of allowing physicians time to transition to HIPAA compliant platforms without the threat of HIPAA audits or other HIPAA enforcement activity. While your Reference Committee heard additional testimony in support of language that would not specify a minimum time for the transition period, your Reference Committee agrees with the testimony offered in support of the 365-day minimum transition period in Resolution

201. Your Reference Committee determined that an alternate resolution would better reflect the intent of the original resolution while addressing additional testimony calling on our AMA to continue advocating that physicians are not subject to HIPAA audits and other HIPAA enforcement activity during the transition period. Therefore, your Reference Committee recommends adoption of alternate Resolution 201 in lieu of 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

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

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 detention 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 already active in issues related to immigration and our policy would benefit from this addition. Your Reference Committee also heard testimony that there was relevant AMA policy that could be amended to include the proposed language of this resolution. As such, your Reference Committee recommends that, to consolidate policy, Resolution 218 be incorporated into current AMA Policy H-350.955. Additionally, your

Reference Committee recommends that AMA Policy H-350.955 be adopted as amended with a change of title that reflects the policy's broader application.

REPORT OF REFERENCE COMMITTEE C

RECOMMENDED FOR ADOPTION

- (1) COUNCIL ON MEDICAL EDUCATION REPORT 1 – COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2011 HOUSE POLICIES

RECOMMENDATION:

The Recommendation in Council on Medical Education Report 1 be adopted and the remainder of the report be filed, with the exception of H-260.978, “Salary Equity for Laboratory Personnel,” which is reaffirmed.

HOD ACTION: Council on Medical Education Report 1 adopted and the remainder of the report filed, with the exception of H-260.978, “Salary Equity for Laboratory Personnel,” which is reaffirmed.

The Council on Medical Education recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Your Reference Committee heard limited, supportive testimony on this item. Testimony from the Pathology Section Council requested that H-260.978, “Salary Equity for Laboratory Personnel,” be reaffirmed rather than rescinded. Particularly during the COVID-19 pandemic, the increased need for laboratory testing underscores the need for highly skilled lab personnel who develop and run these tests is critical to maintaining equitable access to timely, accurate lab results needed both by our care teams and our patients. The Council on Medical Education agreed with the amendment, as does your Reference Committee, which therefore recommends that Council on Medical Education Report 1 be adopted as drafted, with the exception of H-269.978, which is to be reaffirmed.

- (2) COUNCIL ON MEDICAL EDUCATION REPORT 3 – OPTIMIZING MATCH OUTCOMES (RESOLUTION 304-I-19)

RECOMMENDATION:

Recommendations in Council on Medical Education Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 3 adopted and the remainder of the report filed.

1. That our AMA reaffirm Policies D-310.977, “National Resident Matching Program Reform,” H-200.954, “US Physician Shortage,” and D-305.967, “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education.” (Reaffirm HOD Policy)

2. That our AMA encourage the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, National Resident Matching Program, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency. (Directive to Take Action)

Your Reference Committee received supportive testimony in favor of adoption of this item, including online testimony posted by the Academic Physicians Section, Resident and Fellow Section, and Medical Student Section. As noted in the second recommendation of the report, creation of a clearinghouse to assist applicants applying for residency programs will help transparency and simplicity in the Match process and serve to decrease the financial burden and other barriers to a successful match. This report also highlights our AMA’s advocacy and leadership on this issue (through the Coalition for Physician Accountability and other organizations) and our efforts to continue to

change and improve the Match. For these reasons, your Reference Committee recommends adoption of Council on Medical Education Report 3.

- (3) COUNCIL ON MEDICAL EDUCATION REPORT 4 – STUDY EXPEDITING ENTRY OF QUALIFIED IMG PHYSICIANS TO US MEDICAL PRACTICE

RECOMMENDATION:

Recommendations in Council on Medical Education Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 4 adopted and the remainder of the report filed.

1. That American Medical Association (AMA) Policy D-255.980 (1), “Impact of Immigration Barriers on the Nation’s Health,” that reads, “Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine” be reaffirmed. (Reaffirm HOD Policy)

2. That our AMA encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas. (Directive to Take Action)

3. That our AMA encourage the Federation of State Medical Boards and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure—including successes, failures, and barriers to implementation. (Directive to Take Action)

4. That Policy D-255.978, “Study Expediting Entry of Qualified IMG Physicians to US Medical Practice,” be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

Your Reference Committee received supportive testimony in favor of adoption of this item, including online testimony posted by the Academic Physicians Section and the International Medical Graduates Section. Proposed and enacted state licensure and credentialing models, such as those described in the report, may enable physicians to be quickly credentialed and licensed so that they may help address national or international pandemics or state/ regional medical emergencies. Additionally, the state models presented may support additional states’ efforts to assist international medical graduates with credentialing and licensure. For these reasons, your Reference Committee recommends adoption of Council on Medical Education Report 4.

RECOMMENDED FOR ADOPTION AS AMENDED

- (4) COUNCIL ON MEDICAL EDUCATION REPORT 2 – LICENSURE FOR INTERNATIONAL MEDICAL GRADUATES PRACTICING IN U.S. INSTITUTIONS WITH RESTRICTED MEDICAL LICENSES (RESOLUTION 311-A-19)

RECOMMENDATION A:

Recommendation 1 in Council on Medical Education Report 2 be amended by addition and deletion, to read as follows:

1. That our American Medical Association (AMA) advocate that qualified international medical graduates have a pathway for licensure by encouraging encourage state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community to serve as a substitute for

U.S. graduate medical education requirement for physicians seeking full unrestricted licensure and board certification. (Directive to Take Action)

RECOMMENDATION B:

Recommendations in Council on Medical Education Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 2 adopted as amended and the remainder of the report filed.

1. That our American Medical Association (AMA) encourage state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community to serve as a substitute for U.S. graduate medical education requirement for physicians seeking full unrestricted licensure and board certification. (Directive to Take Action)

2. That our AMA amend Policy H-255.988 (12), “AMA Principles on International Medical Graduates,” by addition to read as follows:

Our AMA supports ...12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community. (Modify Current HOD Policy)

3. That our AMA amend Policy H-275.934 (2), “Alternatives to the Federation of State Medical Boards Recommendations on Licensure,” by addition to read as follows:

2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all state-required licensing examinations (USMLE or COMLEX USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement for completing one year of accredited GME in the U.S.: 1) completion of medical school and residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of good standing within the local medical community. (Modify Current HOD Policy)

4. That our AMA amend Policy H-160.949 (6), “Practicing Medicine by Non-Physicians,” by addition and deletion to read as follows:

Our AMA ... (6) opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education ~~of American Osteopathic Association~~ training program, or have not completed at least one year of accredited ~~post-graduate US~~ medical education in the U.S.) (Modify Current HOD Policy)

5. That our AMA amend Policy H-275.978 (5), “Medical Licensure,” by addition to read as follows:

Our AMA ... (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses, with the exception of special licensing pathways for “assistant physicians.” It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (Modify Current HOD Policy)

Your Reference Committee heard testimony in support of this report and its recognition of the needs and dedication of international medical graduates (IMGs). Regarding the first recommendation of the report, testimony noted concern for how “good standing” is being defined; however, your Reference Committee believes it will be addressed in the development of the criteria requested in this report. Testimony also questioned the meaning of “extensive U.S. medical practice” if an IMG is without a license or board certification. Therefore, your Reference Committee has offered amended language of the first recommendation “...to advocate that qualified international medical graduates

have a pathway for licensure...”. Your Reference Committee recommends that Council on Medical Education Report 2 be adopted as amended.

- (5) COUNCIL ON MEDICAL EDUCATION REPORT 5 – PROMISING PRACTICES AMONG PATHWAY PROGRAMS TO INCREASE DIVERSITY IN MEDICINE

RECOMMENDATION A:

Recommendation 1 in Council on Medical Education Report 5 be amended by addition and deletion, to read as follows:

1. That our AMA recognize some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, and gender identity, socioeconomic origin, and rurality, due to ~~structural~~ racism and other systems of oppression, exclusion and discrimination. (New HOD Policy)

RECOMMENDATION B:

Alternate Recommendation 5 in Council on Medical Education Report 5 be adopted in lieu of Recommendation 5, to read as follows:

5. That our AMA amend Policy H-200.951, Strategies for Enhancing Diversity in the Physician Workforce by addition and deletion to read as follows:

Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality ~~persons with disabilities~~; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, “In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce,” and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; ~~and~~ (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that ~~articulating~~ articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this and strategies to accomplish that goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations. (Modify Current HOD Policy).

RECOMMENDATION C:

Alternate Recommendation 6 in Council on Medical Education Report 5 be adopted in lieu of Recommendation 6, to read as follows:

6. That our AMA amend Policy H-60.917, Disparities in Public Education as a Crisis in Public Health and Civil Rights by addition to read as follows: 3. Our AMA will encourage the U.S. Department of Education and Department of Labor to develop policies and initiatives in support of students from marginalized backgrounds that 1) decrease the educational opportunity gap; 2) increase participation in high school Advanced Placement courses; and 3) increase the high school graduation rate. (Modify Current HOD Policy)

RECOMMENDATION D:

Council on Medical Education Report 5 be amended by addition of a ninth Recommendation, to read as follows:

9. That our AMA advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population. (Directive to Take Action)

RECOMMENDATION E:

Council on Medical Education Report 5 be amended by addition of a tenth Recommendation, to read as follows:

10. That our AMA work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates. (Directive to Take Action)

RECOMMENDATION F:

Recommendations in Council on Medical Education Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 5 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 5 amended by addition of an eleventh Recommendation, to read as follows:

11. That our AMA establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.

1. That our AMA recognize some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, sexual orientation, and gender identity due to structural racism and other systems of oppression. (New HOD Policy)
2. That our AMA commit to promoting truth and reconciliation in medical education as it relates to improving equity. (New HOD Policy)
3. That our AMA recognize the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations. (New HOD Policy)
4. That our AMA work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations. (New HOD Policy)
5. That our AMA amend Policy H-200.951, Strategies for Enhancing Diversity in the Physician Workforce by addition and deletion to read as follows: (4) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support historically underrepresented groups in medicine, by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this and strategies to accomplish that goal. (5) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of minoritized and marginalized patient populations. (Modify Current HOD Policy)
6. That our AMA amend Policy H-60.917, Disparities in Public Education as a Crisis in Public Health and Civil Rights (3) by addition to read as follows: Our AMA will support and encourage the U.S. Department of Education to develop policies and initiatives to 1) increase the high school graduation rate among historically underrepresented students 2) increase the number of historically underrepresented students participating in high school Advanced Placement courses and 3) decrease the educational opportunity gap. (Modify Current HOD Policy)
7. That our AMA amend Policy D-200.985 (13), “Strategies for Enhancing Diversity in the Physician Workforce,” by deletion to read as follows: ~~(a) supports the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and.~~ (Modify Current HOD Policy)
8. That our AMA reaffirm Policy D-200.982, “Diversity in the Physician Workforce and Access to Care.”

Your Reference Committee received supportive testimony in favor of adoption of this item, including online testimony posted by the Academic Physicians Section and friendly amendments, proffered by the Medical Student Section, American Academy of Family Physicians, and the New York and Texas delegations, respectively, to support the sustainability of institutions of higher education serving minority populations, mitigate inequities in the selection of medical students for honor societies, and further refine and strengthen Policy H-200.951, “Strategies for Enhancing Diversity in the Physician Workforce.” An amendment from the Minority Affairs Section was considered, but your Reference Committee believed that it was not germane to the report. In the spirit of intersectionality, amendments were also accepted to include people with disabilities and from rural locations in the first resolve. It was also recommended that the Department of Labor be added to the sixth resolve as they also oversee initiatives in public education, and the three clauses in the policy were reordered to enhance readability. Our AMA has evidenced, particularly over the past few years—with the development of the Center for Health Equity and the recent release of the strategic plan on health equity—a significant change in its awareness of, leadership on, and commitment to racial justice and equity within the medical profession and society as a whole. The recommendations put forth by this report, along with the amendments noted, will only accelerate that advocacy and action and represent a critical step towards rectifying the harmful past actions that the medical profession as a whole

and organized medicine have perpetrated on communities of color. The impact of the byzantine legacy of the Flexner Report, in particular Chapter 14 entitled “The Medical Education of the Negro,” must be addressed and reconciled to ensure that future physicians are aware of structural factors that are impeding their patient’s health outcomes. For these reasons, your Reference Committee recommends that Council on Medical Education Report 5 be adopted as amended.

(6) RESOLUTION 305 – NON-PHYSICIAN POST-GRADUATE MEDICAL TRAINING

RECOMMENDATION A:

The first Resolve of Resolution 305 be amended by deletion, to read as follows:

~~RESOLVED, That our American Medical Association believe that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual’s training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels) (New HOD Policy); and be it further~~

RECOMMENDATION B:

Alternate Resolve 2 in Resolution 305 be adopted in lieu of Resolve 2, to read as follows:

RESOLVED, That our AMA amend policy H-275.925 “Protection of the Titles ‘Doctor,’ ‘Resident’ and ‘Residency,’” by addition and deletion to read as follows:

Our AMA: (1) recognizes that when used in the healthcare setting, specific terms describing various levels of allopathic and osteopathic physician training and practice (including the terms “medical student,” “resident,” “residency,” “fellow,” “fellowship,” “physician,” and “attending”) represent the completion of structured, rigorous, medical education undertaken by physicians (as defined by the American Medical Association in H-405.951, “Definition and Use of the Term Physician”), and must be reserved for describing only physician roles; (2) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and (3) supports and develops model state legislation that would penalize misrepresentation of one’s role in the physician-led healthcare team, up to and including the level of make it a felony to for misrepresenting oneself as a physician (MD/DO); and (4) support and develop model state legislation that calls for statutory restrictions for non-physician post-graduate diagnostic and clinical training programs using the terms “medical student,” “resident,” “residency,” “fellow,” “fellowship,” “physician,” or “attending” in a healthcare setting except by physicians. (Modify Current HOD Policy); and be it further

RECOMMENDATION C:

The third Resolve of Resolution 305 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA study and report back to the House of Delegates, by the 2022 Annual Meeting, on curriculum, accreditation requirements, accrediting bodies, and supervising boards for undergraduate, graduate, and postgraduate clinical training programs for non-physicians and the impact of non-physician graduate clinical education on physician undergraduate and graduate medical education (Directive to Take Action); and be it further

RECOMMENDATION D:

Policy H-310.916 be reaffirmed in lieu of the fourth Resolve of Resolution 305.

RECOMMENDATION E:

The fifth Resolve of Resolution 305 be amended by deletion, to read as follows:

~~**RESOLVED**, That our AMA partner with the Accreditation Council for Graduate Medical Education (ACGME) to create standards requiring Designated Institutional Officials to notify the ACGME of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships (Directive to Take Action); and be it further~~

RECOMMENDATION F:

The eighth Resolve of Resolution 305 be amended by deletion, to read as follows:

~~**RESOLVED**, That our AMA oppose non-physician healthcare providers from holding a seat on the board of an organization that regulates and/or provides oversight of physician undergraduate and graduate medical education, accreditation, certification, and credentialing when these types of non-physician healthcare providers either possess or seek to possess the ability to practice without physician supervision as it represents a conflict of interest. (Directive to Take Action)~~

RECOMMENDATION G:

Resolution 305 be adopted as amended

HOD ACTION: Resolution 305 adopted as amended as follows:

The first Resolve of Resolution 305 adopted, to read as follows:

RESOLVED, That our American Medical Association believe that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels) (New HOD Policy); and be it further

Alternate Resolve 2 in Resolution 305 referred.

The eighth Resolve of Resolution 305 referred.

RESOLVED, That our American Medical Association believe that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels) (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-275.925 "Protection of the Titles "Doctor," "Resident" and "Residency"," by addition and deletion to read as follows:

Our AMA:

(1) recognize that the terms "medical student," "resident," "residency," "fellow," "fellowship," "physician," and "attending," when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians, as defined by the Centers for Medicare and Medicaid Services, and thus these terms must be reserved only to describe physician roles; (2) advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; (3) supports and develop model state legislation that would penalize misrepresentation of one's role in the physician-led healthcare team, up to and including to make it a felony to misrepresent oneself as a physician (MD/DO); and (4) support and develop model state legislation that calls for statutory restrictions for non-physician post-graduate diagnostic and clinical training programs using the terms "medical student," "resident," "residency," "fellow," "fellowship," "physician," or "attending" in a healthcare setting except by physicians. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA study and report back, by the 2022 Annual Meeting, on curriculum, accreditation requirements, accrediting bodies, and supervising boards for graduate and postgraduate clinical training programs for non-physicians and the impact of non-physician graduate clinical education on physician graduate medical education (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the expansion of post-graduate clinical training for non-physicians do not divert funding from physician GME (Directive to Take Action); and be it further

RESOLVED, That our AMA partner with the Accreditation Council for Graduate Medical Education (ACGME) to create standards requiring Designated Institutional Officials to notify the ACGME of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships (Directive to Take Action); and be it further

RESOLVED, That policy H-310.912 "Resident and Fellow Bill of Rights," be amended by addition and deletion to read as follows:

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows ~~should expect supervision by physicians and non-physicians~~ must be ultimately supervised by physicians who are adequately qualified and ~~which~~ allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. ~~It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.~~ In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose non-physician healthcare providers from holding a seat on the board of an organization that regulates and/or provides oversight of physician undergraduate and graduate medical education, accreditation, certification, and credentialing when these types of non-physician healthcare providers either possess or seek to possess the ability to practice without physician supervision as it represents a conflict of interest. (Directive to Take Action)

Your Reference Committee heard testimony in support of this resolution, which contains eight resolves. Your Reference Committee is sensitive to the concerns related to the impact of non-physicians on graduate medical education. The Council on Medical Education provided recommendations to address the various pieces of this resolution. Your Reference Committee appreciates the expert guidance of the Council and all who contributed to the testimony.

Resolve 1: Given that the salaries of health care trainees are under the purview of the programs/institutions, your Reference Committee recommends that the first resolve be deleted.

Resolve 2: Your Reference Committee is sensitive to the use of terms like “fellow” and “fellowship” which are used in a variety of contexts, many of them non-medical. Also, “resident” and “residencies” for non-physicians exist in other countries. Your Reference Committee offered amendments to the first clause to provide clarity, as well as to support the AMA definition of a physician. Amendments to the third clause and the addition of a fourth clause support model state legislation in keeping with AMA policy and the AMA’s Truth in Advertising campaign.

Resolve 3: Your Reference Committee recognizes the value of studying this issue and appreciates the Council on Medical Education’s willingness to do so. It was recommended that a report back date is best determined by the Council and should not be included in this language. Also, your Reference Committee recommends including undergraduates in this study. As such, your Reference Committee recommends the third resolve be adopted as amended.

Resolve 4: Your Reference Committee recognized that AMA policy advocates that funds to support the expansion of post-graduate clinical training for non-physicians do not divert funding from physicians. Your Reference Committee was informed that the AMA Advocacy team is actively engaged in these efforts; therefore, it is recommended that Policy H-310.916, “Funding to Support Training of the Health Care Workforce,” be reaffirmed in lieu of the fourth resolve.

Resolve 5: Your Reference Committee deliberated on the best way to address proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships. It was clarified that the request in this resolve is already reflected in the Accreditation Council for Graduate Medical Education common program requirements, which include a standard to address this issue. Your Reference Committee, accordingly, recommends that the fifth resolve be deleted.

Resolve 6: Your Reference Committee appreciates the author’s language to amend policy H-310.912, “Residents and Fellows’ Bill of Rights,” to clarify the role of physicians as supervisors. Your Reference Committee recommends that the sixth resolve be adopted as amended.

Resolve 7: Your Reference Committee acknowledged the importance of the Resident and Fellows’ Bill of Rights and its dissemination such that residency and fellowship training programs embody these principles. It was noted that the AMA has promoted this policy through *AMA MedEd Update* and other mechanisms. Your Reference Committee recommends that the seventh resolve be adopted.

Resolve 8: Your Reference Committee appreciated the concern for non-physician health care providers holding a seat on an oversight board and the conflict of interest it may pose. However, your Reference Committee is aware of boards in which a non-physician seat is valuable (e.g., institutional review board, hospital medical quality board, or medical specialty board). Given the complicated existing systems, your Reference Committee recommends that the eighth resolve be deleted.

While some testimony supported referral of this nuanced resolution, your Reference Committee felt it was sufficient to address the various pieces at this time. In sum, your Reference Committee recommends that Resolution 305 be adopted as amended.

**Policy recommended for reaffirmation:
H-310.916, “Funding to Support Training of the Health Care Workforce”**

1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.

2. Our AMA strongly advocates that: (A) there be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions; and (B) there be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.

3. Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs.

(7) RESOLUTION 309 – SUPPORTING GME PROGRAM CHILD CARE CONSIDERATION DURING RESIDENCY TRAINING

RECOMMENDATION A:

Resolution 309 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~convene work with a group of interested stakeholders to examine the need~~ investigate solutions for innovative childcare policies and flexible working environments for all health care professionals (in particular, medical students and physician trainees) residents in order to promote equity in all training settings. (Directive to Take Action)

RECOMMENDATION B:

Resolution 309 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 309 be changed, to read as follows:

SUPPORTING CHILD CARE FOR HEALTH CARE PROFESSIONALS

HOD ACTION: Resolution 309 adopted as amended with a change in title to read as follows:

SUPPORTING CHILD CARE FOR HEALTH CARE PROFESSIONALS

RESOLVED, That our American Medical Association convene a group of interested stakeholders to examine the need for innovative childcare policies and flexible working environments for all residents in order to promote equity in all training settings. (Directive to Take Action)

Your Reference Committee heard unanimous supportive testimony for this resolution. AMA policy supports flexible working environments to accommodate childcare needs. Testimony from the Council on Medical Education recommended referral for further study; however, other testimony pointed out the timely need for equitable childcare support for physician trainees and medical students as well as the full health care team, and the desire for the AMA to investigate solutions. This goal can be accomplished through working with interested stakeholders. As such, your Reference Committee recommends that Resolution 309 be adopted as amended.

- (8) RESOLUTION 310 – UNREASONABLE FEES CHARGED AND INACCURACIES BY THE AMERICAN BOARD OF INTERNAL MEDICINE (ABIM)

RECOMMENDATION A:

Resolution 310 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with the American Board of Medical Specialties Boards (ABMS) and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures. ~~in general, and American Board of Internal Medicine (ABIM), specifically, to require the ABIM stop charging physicians with two or more board certifications, who participate in Maintenance of Certification (MOC) with a board other than the ABIM, a fee to accurately list their current board status in the ABIM Directory.~~ (Directive to Take Action). (Directive to Take Action)

RECOMMENDATION B:

Resolution 310 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 310 be changed, to read as follows:

UNREASONABLE FEES CHARGED BY ABMS MEMBER BOARDS

HOD ACTION: Resolution 310 adopted as amended with a change in title to read as follows:

UNREASONABLE FEES CHARGED BY ABMS MEMBER BOARDS

RESOLVED, That our American Medical Association work with the American Board of Medical Specialties Boards (ABMS), in general, and American Board of Internal Medicine (ABIM), specifically, to require the ABIM stop charging physicians with two or more board certifications, who participate in Maintenance of Certification (MOC) with a board other than the ABIM, a fee to accurately list their current board status in the ABIM Directory. (Directive to Take Action)

Your Reference Committee heard testimony in support of amended language to this resolution, to include the support of the American Board of Internal Medicine, as offered by the Council on Medical Education. AMA policy supports the reduction of unnecessary burdens on individuals holding multiple certifications and discourages fee structures aimed at financial gain. Your Reference Committee was made aware that the American Board of Medical Specialties (ABMS) Standards are currently in a Call for Comment period, with a recommendation aimed at developing reciprocity between member boards for requirements to reduce the burden on diplomates of multiple boards. The amended language would allow our AMA to comment as well on the impact of multiple fees to practicing physicians by all member boards of the ABMS, including ABIM. The committee developed language to allow the AMA to work with both the ABMS and its member boards directly, to increase the odds of a successful outcome. Therefore, your Reference Committee recommends that Resolution 310 be adopted as amended with a change in title.

- (9) RESOLUTION 318 – THE IMPACT OF PRIVATE EQUITY ON MEDICAL TRAINING

RECOMMENDATION A:

Resolution 318 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with relevant stakeholders including specialty societies and the Accreditation Council for Graduate Medical Education to study the level of financial involvement and influence private equity firms have in graduate medical education training programs and report back to the House of Delegates, at the 2021 Interim Meeting with possible concurrent publication of their findings in a peer-reviewed journal. (Directive to Take Action)

RECOMMENDATION B:

Resolution 318 be adopted as amended.

HOD ACTION: Resolution 318 adopted as amended.

RESOLVED, That our American Medical Association work with relevant stakeholders including specialty societies and the Accreditation Council for Graduate Medical Education to study the level of financial involvement and influence private equity firms have in graduate medical education training programs and report back at the 2021 Interim Meeting with concurrent publication of their findings in a peer-reviewed journal. (Directive to Take Action)

Your Reference Committee heard mixed testimony on this item. Online testimony posted by the American Society of Hematology raised the specter of Hahnemann, when 550 trainees were suddenly stuck in limbo without new training sites or a clear pathway to independent practice, not to mention the impact on faculty and staff, along with the surrounding community losing a safety-net hospital. Subsequently, a \$55 million winning bid for those GME-funded training positions came from a consortium of hospitals—the direct result of private equity interfering in GME. Additional testimony noted an ongoing study on the impact of private equity and corporate investors on medical practice by the Council on Medical Service, but medical education is not likely to be encompassed in the subsequent CMS report. Testimony by the Council on Medical Education, while recognizing the urgency of this issue, noted that a sound and well researched study cannot be accomplished by November and requested amending the resolution to delete the time-certain requirement. In addition, your Reference Committee noted that peer-reviewed journals have various manuscript style requirements, and acceptance for publication of an incomplete study cannot be guaranteed. Furthermore, the House of Delegates may wish to review the findings before recommending publication and may find it desirable for publication in other than a peer-reviewed journal. Your Reference Committee therefore recommends that Resolution 318 be adopted as amended.

- (10) RESOLUTION 319 – THE EFFECT OF THE COVID-19 PANDEMIC ON GRADUATE MEDICAL EDUCATION

RECOMMENDATION A:

The first Resolve of Resolution 319 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with ~~the Accreditation Council for Graduate Medical Education (ACGME) and other~~ relevant stakeholders to advocate for provide additional, equitable compensation and benefits ~~for compensation, such as moonlighting, hazard pay, and/or additional certifications~~ for residents and fellows who are redeployed to fulfill service needs that may be ~~are~~ outside the scope of their specialty training (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 319 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA urge ACGME to work with relevant stakeholders including residency and fellowship programs to ensure each graduating resident or fellow is provided with documentation explicitly stating his/her board eligibility and identifying areas of training that have been impacted by COVID-19 that can be presented to the respective board certifying committee (Directive to Take Action); and be it further~~

RECOMMENDATION C:

The third Resolve of Resolution 319 be amended by addition and deletion, to read as follows:

~~RESOLVED, That our AMA urge ACGME and specialty boards to consider reducing replacing minimums on case numbers and clinic visits with revised more holistic measures to recognize resident/fellow learning, indicate readiness for graduation and board certification eligibility, especially given the drastic educational barriers confronted during the COVID-19 pandemic. (Directive to Take Action)~~

RECOMMENDATION D:

Resolution 319 be adopted as amended.

HOD ACTION: Resolution 319 adopted as amended.

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to provide additional benefits for compensation, such as moonlighting, hazard pay, and/or additional certifications for residents and fellows who are redeployed to fulfill service needs that are outside the scope of their specialty training (Directive to Take Action); and be it further

RESOLVED, That our AMA urge ACGME to work with relevant stakeholders including residency and fellowship programs to ensure each graduating resident or fellow is provided with documentation explicitly stating his/her board eligibility and identifying areas of training that have been impacted by COVID-19 that can be presented to the respective board certifying committee (Directive to Take Action); and be it further

RESOLVED, That our AMA urge ACGME and specialty boards to consider replacing minimums on case numbers and clinic visits with more holistic measures to indicate readiness for graduation and board certification eligibility, especially given the drastic educational barriers confronted during the COVID-19 pandemic. (Directive to Take Action)

Your Reference Committee received supportive testimony on this item. Online testimony posted by the Georgia delegation highlighted the long-term consequences of the pandemic on graduate medical education and the nation's future health care workforce. Both the Academic Physicians Section and Council on Medical Education, while in support of the spirit of this item, proffered revisions to the language to clarify specific aspects, such as the need for equitable compensation for trainees compared to other health care professionals who provided additional services during the pandemic. The Council on Medical Education also testified that Resolve 2 is encompassed by Resolve 3, and therefore recommended its deletion. Your Reference Committee agrees with this and other helpful editorial and substantive suggestions, and therefore recommends that Resolution 319 be adopted as amended.

RECOMMENDED FOR REFERRAL

- (11) RESOLUTION 304 – DECREASING FINANCIAL BURDENS ON RESIDENTS AND FELLOWS

RECOMMENDATION:

Resolution 304 be referred.

**HOD ACTION: Resolve 3 of Resolution 304 referred.
Remainder of Resolution 304 adopted as amended, to read as follows:**

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to advocate for additional ways to defray costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to define “access to food” for medical trainees to include overnight access to fresh food and healthy meal options within all training hospitals (Directive to Take Action); and be it further

RESOLVED, That the Residents and Fellows’ Bill of Rights be prominently published online on the AMA website and be disseminated to residency and fellowship programs (Directive to Take Action); and be it further

RESOLVED, That the AMA Policy H-310.912, “Residents and Fellows’ Bill of Rights,” be amended by addition and deletion to read as follows:

5. Our AMA partner with ACGME and other relevant stakeholders to encourages training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation. (Modify Current HOD Policy)

RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME), the Association of American Medical Colleges (AAMC), and other relevant stakeholders to advocate that medical trainees not be required to pay for essential amenities and/or high cost or safety-related, specialty-specific equipment required to perform clinical duties (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders including the AAMC to define “access to food” for medical trainees to include 24-hour access to fresh food and healthy meal options within all training hospitals (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to ensure that medical trainees have access to on-site and subsidized childcare (Directive to Take Action); and be it further

RESOLVED, That the Residents and Fellows’ Bill of Rights be prominently published online on the AMA website and be disseminated to residency and fellowship programs (Directive to Take Action); and be it further

RESOLVED, That the AMA Policy H-310.912, “Residents and Fellows’ Bill of Rights,” be amended by addition and deletion to read as follows:

5. Our AMA partner with ACGME and other relevant stakeholders to encourages training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services. ~~teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.~~ (Modify Current HOD Policy)

Your Reference Committee heard unanimous testimony in support of the sentiment of this resolution. Testimony noted the burdens placed upon trainees who have been asked to purchase essential equipment, uniforms, or other attire without being reimbursed, as well as support to advocate for benefits for trainees including meal allowances, transportation support, and childcare services. Testimony also expressed concern for the financial impacts on hospitals and programs in order to implement such expanded services, as well as funding for graduate medical education overall. AMA policy is supportive of eliminating barriers to student and resident debt, healthy food options in hospitals for staff and patients, and the childcare needs of physicians and trainees. The Council on Medical Education requested that this resolution be referred to give them the opportunity to explore this topic further and then formulate recommendations on ways to reduce financial burdens on trainees while also maintaining equity both among trainees and equity among all healthcare workers. As such, your Reference Committee recommends that Resolution 304 be referred.

- (12) RESOLUTION 314 – STANDARD PROCEDURE FOR ACCOMMODATIONS IN USMLE AND NBME EXAMS

RECOMMENDATION:

Resolution 314 be referred.

HOD ACTION: Resolution 314 referred for decision.

RESOLVED, That our American Medical Association collaborate with medical licensing organizations to facilitate a timely accommodations application process (Directive to Take Action); and be it further

RESOLVED, That our AMA, in conjunction with the National Board of Medical Examiners, develop a plan to reduce the amount of proof required for approving accommodations to lower the burden of cost and time to medical students with disabilities. (Directive to Take Action)

Your Reference Committee heard largely supportive testimony on this item and believes that advocating for disability inclusion in medicine is an important role for our AMA. Online testimony posted by the Council on Medical Education and Academic Physicians Section called for edits to both Resolves 1 and 2, to indicate specifically the licensing organizations in question (in Resolve 1) and to change the focus of Resolve 2 to require the boards’ adherence to the Americans with Disabilities Act. The National Board of Medical Examiners (NBME) posted a lengthy defense of its practices—for example, that accommodations may affect exam standardization and comparable validity of examination results—and recommended not adopting Resolution 314. Other testimony posted by individuals and the Medical Student Section, however, disputed the NBME’s claims and provided compelling anecdotal data to suggest that medical students with disabilities face undue burdens in attaining needed accommodations for these required examinations. The Council on Medical Education also notes that some of these issues could be integrated into a currently scheduled report for the November meeting on trainees with disabilities. Due to the complexity of issues surrounding these examinations, questions about legal implications, and the importance of this issue, your Reference Committee recommends referral of Resolution 314.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

- (13) RESOLUTION 308 – RESCIND USMLE STEP 2 CS AND COMLEX LEVEL 2 PE EXAMINATION REQUIREMENT FOR MEDICAL LICENSURE

RECOMMENDATION:

Policy D-295.988 be reaffirmed in lieu of Resolution 308.

HOD ACTION: Policy D-295.988 reaffirmed in lieu of Resolution 308.

RESOLVED, That our American Medical Association work to rescind USMLE Step 2 CS and COMLEX Level 2 PE examination requirements and encourage a “fifty-state approach” by all individual state medical societies to engage with their respective state medical boards on this issue. (Directive to Take Action)

Your Reference Committee heard supportive testimony for this resolution as well as testimony regarding reaffirmation of AMA Policy D-295.988, “Clinical Skills Assessment During Medical School,” in lieu of the resolution. Your Reference Committee noted that the USMLE Step 2 CS examination was suspended on March 16, 2020 and formally discontinued on January 26, 2021. Also, the NBOME COMLEX-USA Level 2 PE examination was suspended on March 20, 2020 and postponed indefinitely on February 11, 2021. Your Reference Committee noted the concern and uncertainty about the future of COMLEX-USA. Policy D-295.988 supports that both these exams be replaced with either an LCME-accredited or a COCA-accredited medical school-administered examination of clinical skills. Your Reference Committee believes that current policy effectively addresses this concern and therefore recommends that Policy D-295.988 be reaffirmed in lieu of Resolution 308.

Policy recommended for reaffirmation:**D-295.988, “Clinical Skills Assessment During Medical School”**

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should “develop a system of assessment” to assure that students have acquired and can demonstrate core clinical skills.
2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation’s medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.
4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.

5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.

6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.

7. Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary.

(14) RESOLUTION 311 – STUDENT LOAN FORGIVENESS

RECOMMENDATION:

Policy H-305.925 be reaffirmed in lieu of Resolution 311.

HOD ACTION: Policy H-305.925 reaffirmed in lieu of Resolution 311.

RESOLVED, That our American Medical Association study the cause for the unacceptably high denial rate of applications made to the Public Health Services Student Loan Forgiveness Program, and advocate for improvements in the administration and oversight of the Program, including but not limited to increasing transparency of and streamlining program requirements; ensuring consistent and accurate communication between loan services and borrowers; and establishing clear expectations regarding oversight and accountability of the loan servicers responsible for the program. (Directive to Take Action)

Your Reference Committee is supportive of the intent of this resolution; that said, testimony was mixed testimony on this item. Online testimony posted by the Council on Medical Education and Academic Physicians Section called for reaffirmation of current (and in-depth) AMA policy on the Public Service Loan Forgiveness (PSLF) Program—specifically, Policy H-305.925—along with incorporating specific asks of the resolution (e.g., the “reasons for denial and transparency”) into a Council report on medical student debt scheduled for a future House of Delegates meeting. Testimony from the Medical Student Section and American Academy of Pediatrics, in contrast, called for adoption as written. All those providing testimony, however, agreed that this is an important topic for AMA study and advocacy. As the Council on Medical Education’s study is slated for release in 2021, your Reference Committee believes that the most expeditious and efficient course of action is incorporation of the “reasons for denial and transparency” of the Public Health Services Student Loan Forgiveness program into the forthcoming Council report and reaffirmation of AMA Policy H-305.925 in lieu of Resolution 311.

Policy recommended for reaffirmation:

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

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

PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

REPORT OF REFERENCE COMMITTEE D

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 15 – REMOVING THE SEX DESIGNATION FROM THE PUBLIC PORTION OF THE BIRTH CERTIFICATE

RECOMMENDATION:

Recommendation in Board of Trustees Report 15 be adopted and the rest of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 15 adopted and the rest of the report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 5-I-19 and the remainder of this report be filed.

Our American Medical Association will advocate for the removal of sex as a legal designation on the public portion of the birth certificate, recognizing that information on an individual's sex designation at birth will still be submitted through the U.S. Standard Certificate of Live Birth for medical, public health, and statistical use only. (Directive to Take Action).

Your Reference Committee heard testimony in strong support of Board of Trustees Report 15. It was acknowledged that this recommendation will help prevent discrimination and will be life-changing for many people, while maintaining our nation's vital statistics for public health and research purposes. Therefore, your Reference Committee recommends that Board of Trustees Report 15 be adopted.

- (2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 – COUNCIL ON SCIENCE AND PUBLIC HEALTH SUNSET REVIEW OF 2011 HOUSE POLICIES

RECOMMENDATION:

Recommendation in Council on Science and Public Health Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in Council on Science and Public Health Report 1 adopted and the remainder of the report filed.

The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Your Reference Committee heard no testimony in opposition to the CSAPH 1. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 1 be adopted.

- (3) RESOLUTION 417 – AMENDMENT TO FOOD ENVIRONMENTS AND CHALLENGES ACCESSING HEALTHY FOOD, H-150.925

RECOMMENDATION:

Resolution 417 be adopted.

HOD ACTION: Resolution 417 adopted.

RESOLVED, That our AMA amend policy H-150.925, Food Environments and Challenges Accessing Healthy Food by insertion and deletion as follows:

Food Environments and Challenges Accessing Healthy Food H-150.925

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to ~~the problems of food mirages, food swamps, and food oases as food environments distinct from food deserts~~ challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; and (2) recognize that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) support policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food. (Modify Current HOD Policy)

Your Reference Committee heard limited, but supportive testimony on Resolution 417. It was noted that the COVID-19 pandemic in particular highlights our nation's problems with food insecurity. Addressing inequities as well as the economic barriers to food access is necessary to solve this public health problem and achieve proper nutrition at all life stages. Your Reference Committee agrees and, therefore, recommends that Resolution 417 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(4) BOARD OF TRUSTEES REPORT 10 – PROTESTER PROTECTIONS

RECOMMENDATION A:

Recommendation in Board of Trustees Report 10 be amended by deletion to read as follows:

Less-Lethal Weapons and Crowd Control

Our American Medical Association (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control peaceful crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm. (New HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: Board of Trustees Report 10 adopted as amended and the remainder of the report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 409, November 2020 Special Meeting, and the remainder of this report be filed.

Less-Lethal Weapons and Crowd Control

Our American Medical Association (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control peaceful crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm. (New HOD Policy)

Testimony provided was overall supportive of Board of Trustees Report 10. The Board noted that the right of assembly plays a fundamental role in public participation in democracy, expressing the will of the people, and in amplifying the voices of people who are marginalized. Those who commented acknowledged that less lethal weapons come with their own risks and there is documented morbidity and mortality associated with their use. The Board's recommendation puts AMA policy in line with other medical specialty societies that have opposed rubber bullets as a means of crowd control. An amendment was suggested to remove the word "peaceful" since the language is redundant with "not posing an imminent threat." Your Reference Committee agrees and therefore recommends that Board of Trustees Report 10 be adopted as amended.

- (5) BOARD OF TRUSTEES REPORT 16 – FOLLOW-UP ON ABNORMAL MEDICAL TEST FINDINGS

RECOMMENDATION A:

Recommendation in Board of Trustees Report 16 be amended by addition to read as follows:

Our AMA supports the development of best practices and other clinical resources for communication of test results, including via patient portals and applications, and encourages additional research to ensure these innovative approaches and tools reach their potential to help advance patient care, while ensuring appropriate privacy safeguards.

RECOMMENDATION B:

Recommendation in Board of Trustees Report 16 be adopted as amended and the rest of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 16 adopted as amended and the rest of the report filed.

The Board of Trustees recommends that the language below be adopted in lieu of Resolution 309-I-19 and the remainder of this report be filed.

Our American Medical Association encourages relevant national medical specialty societies to develop and disseminate evidence-based guidelines for communication and follow-up of abnormal and critical test results to promote better patient outcomes. (New HOD Policy)

Our AMA will work with appropriate state and medical specialty societies to highlight relevant education regarding the communication and follow-up of abnormal and critical medical test findings to promote better patient outcomes. (Directive to Take Action)

Our AMA supports the development of best practices and other clinical resources for communication of test results, including via patient portals and applications, and encourages additional research to ensure these innovative approaches and tools reach their potential to help advance patient care. (New HOD Policy)

Your Reference Committee heard testimony largely in support of Board of Trustees Report 16. Testimony reaffirmed the importance of reporting test results in a timely manner and coordinated communication to ensure patient safety. The inclusion of medical specialty societies' role to develop evidence-based guidelines for communicating abnormal test results with patients also received positive feedback. An amendment was proposed to ensure appropriate privacy safeguards are in place for patient portals and applications. Your Reference Committee agrees with this amendment and recommends that Board of Trustees Report 16 be adopted as amended.

- (6) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 – ADDRESSING INCREASES IN YOUTH SUICIDE

RECOMMENDATION A:

Recommendation 1 in Council and Science and Public Health Report 3 be amended by addition and deletion to read as follows:

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

- 1. That Policy H-60.937 be amended to read as follows:
~~Teen Youth~~ and Young Adult Suicide in the United States**

Our AMA:

- (1) Recognizes ~~teen youth~~ and young adult suicide as a serious health concern in the US;**
- (2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;**
- (3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;**

- (4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
- (5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, and Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;
- (6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults; and
- (7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools.
- (8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic.
- (9) That our AMA advocate at the state and national level for policies to prioritize children’s mental, emotional and behavioral health.
- (10) That our AMA advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents.
- (11) That our AMA consider supporting the Child and Adolescent Mental and Behavioral Health Principles 2021 developed by the American Academy of Pediatrics and partner organizations including AACAP, APA and Children’s Hospital Association among others, and join with these and other partner organizations in advocating for a comprehensive approach to the child and adolescent mental and behavioral health crisis. (Modify Current HOD policy)

RECOMMENDATION B:

Recommendation 2 in Council on Science and Public Health Report 3 be amended by addition to read as follows:

1. That Policy H-515-952, “Adverse Childhood Experiences and Trauma-Informed Care” be amended by addition to read as follows:
 1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.
 2. Our AMA supports:
 - a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
 - b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;

- c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
 - d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
 - e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
 - f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes.
- 3. Our AMA supports the inclusion of ACEs and trauma-informed care into undergraduate and graduate medical education curricula.**
(Modify Current HOD policy)

RECOMMENDATION C:

The recommendations in Council on Science and Public Health Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendation 1, item 11 referred for decision.

All other Recommendations in Council on Science and Public Health Report 3 adopted as amended and the remainder of the report filed.

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

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

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

Our AMA:

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

2. That Policy H-515-952, “Adverse Childhood Experiences and Trauma-Informed Care” be amended by addition to read as follows:

1. Our AMA recognizes trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization.

2. Our AMA supports:

- a. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
- b. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma at any time in life occurs;
- c. efforts for data collection, research, and evaluation of cost-effective ACEs screening tools without additional burden for physicians.
- d. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
- e. funding for schools, behavioral and mental health services, professional groups, community, and government agencies to support patients with ACEs or trauma at any time in life; and
- f. increased screening for ACEs in medical settings, in recognition of the intersectionality of ACEs with significant increased risk for suicide, negative substance use-related outcomes including overdose, and a multitude of downstream negative health outcomes. (Modify Current HOD policy)

3. That Policy H-145.975, “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care,” which recognizes the role of firearms in suicides; encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling; and encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide, be reaffirmed. . (Reaffirm Current HOD Policy).

4. That Policy H-170.984, “Healthy Living Behaviors,” encouraging state medical societies and physicians to promote physical and wellness activities for children and youth and to advocate for health and wellness programs for children and youth in schools and communities, be reaffirmed. (Reaffirm Current HOD Policy)

The Council was applauded for its timely report on the issue of youth suicide. It was recognized that as a nation we need to enhance our efforts related to suicide prevention and risk mitigation, and the recommendations in this report are an important step forward. Proposed amendments supported the inclusion of adverse childhood experiences and trauma-informed care into the undergraduate and graduate medical education curricula and also recognized youth with disabilities as a subpopulation at risk. These amendments were supported by your Reference Committee. The American Academy of Pediatrics suggested the addition of four Resolve statements, one of which called upon the AMA to bring attention to the mental health crisis in youth and young adults as a result of the COVID-19 pandemic. Your Reference Committee agrees that recommendation is in line with and supported by the Council’s report. The other three resolves were broader and while it was felt that they are of importance, they are beyond the focus and evidence-base addressed in this report. Additionally, whether or not the AMA should endorse the Child and Adolescent Mental and Behavioral Health Principles of 2021 is a decision that can be made by the AMA without a directive to study. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 3 be adopted as amended.

- (7) RESOLUTION 406 – ATTACKING DISPARITIES IN COVID-19 UNDERLYING HEALTH CONDITIONS

RECOMMENDATION A:

Resolution 406 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association urge federal, state, and municipal leaders to prominently note in their COVID-19 public health advisories the urgent need for individuals with underlying health medical conditions, particularly obesity, type 2 diabetes, and hypertension, to consult with their physicians to assess their health

~~medical status and institute (or resume) appropriate treatment, which may range from updating medications and lifestyle changes, such as reduced sodium and plant-based diets and physical activity, to aggressive medical therapy which may include medication, surgery, and complex multi-disciplinary care. (Directive to Take Action)~~

RECOMMENDATION B:

Resolution 406 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 406 be changed to read as follows:

**ADDRESSING UNDERLYING HEALTH CONDITIONS
ASSOCIATED WITH RISK FOR SEVERE COVID-19**

HOD ACTION: Resolution 406 adopted as amended with change in title to read as follows:

**ADDRESSING UNDERLYING HEALTH CONDITIONS
ASSOCIATED WITH RISK FOR SEVERE COVID-19**

RESOLVED, That our American Medical Association urge federal, state, and municipal leaders to prominently note in their COVID-19 public health advisories the urgent need for individuals with underlying medical conditions, particularly obesity, type 2 diabetes, and hypertension, to consult with their physicians to assess their medical status and institute (or resume) appropriate treatment, which may range from updating medications and lifestyle changes, such as reduced sodium and plant-based diets and physical activity, to aggressive medical therapy which may include medication, surgery, and complex multi-disciplinary care. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 406 given the role of underlying chronic conditions in making individuals more severely ill from COVID-19. Several of those who testified wished to see modifications to the conditions included in notices, such as the inclusion of mental and behavioral health, but your Reference Committee believes that more comprehensive language to be inclusive of any pre-existing condition will give the greatest flexibility for government leaders to address the populations they serve. Additionally, your Reference Committee believes that alerts from federal, state, and municipal leaders on this topic should not suggest specific treatments but rather should encourage individuals to consult with their physician. Therefore, your Reference Committee recommends that Resolution 406 be adopted as amended.

- (8) RESOLUTION 407 – IMPACT OF SARS-COV-2 PANDEMIC ON POST-ACUTE CARE SERVICES AND LONG-TERM CARE AND RESIDENTIAL FACILITIES

RECOMMENDATION A:

Resolution 407 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~advocate for study of the impact of SARS-CoV-2 pandemic on post-acute care services and long-term care and residential facilities and~~ collaborate with other stakeholders to develop policy to guide federal, state, and local public health authorities to ensure safe operation of these Post-Acute Care (PAC) and long-term care (LTC) facilities during public health emergencies and natural disasters with policy recommendations to include but not limited to:

- a) **Planning for adequate funding and access to resources;**

- b) **Planning for emergency staffing of health care and maintenance personnel;**
- c) **Planning for ensuring safe working conditions of PAC and LTC staff; and**
- d) **Planning for mitigation of the detrimental effects of increased isolation of residents during a natural disaster, other environmental emergency, or pandemic, or similar crisis. (Directive to Take Action)**

RECOMMENDATION B:

Resolution 407 be adopted as amended.

HOD ACTION: Resolution 407 adopted as amended.

RESOLVED, That our American Medical Association study the impact of SARS-CoV-2 pandemic on post-acute care services and long-term care and residential facilities and collaborate with other stakeholders to develop policy to guide federal, state, and local public health authorities to ensure safe operation of these facilities during public health emergencies and natural disasters with policy recommendations to include but not limited to:

- a) Planning for adequate funding and access to resources;
- b) Planning for emergency staffing of health care and maintenance personnel;
- c) Planning for ensuring safe working conditions of LTC staff; and
- d) Planning for mitigation of the detrimental effects of increased isolation of residents during a natural disaster, other environmental emergency, or pandemic, or similar crisis. (Directive to Take Action)

Your Reference Committee heard testimony in support of the intent of Resolution 407, but questions were raised as to whether the AMA is in the best position to conduct this study. Testimony noted that health care personnel and residents of long-term care (LTC) facilities have been disproportionately impacted by the Covid-19 pandemic. LTC residents tend to be older adults, immune-compromised and live in a group setting. Furthermore, reports indicate that increased isolation may have long-lasting effects on the mental health of LTC residents. The Council on Science and Public Health spoke politely in opposition to the AMA studying this issue, as those with direct, on the ground experience in responding to the pandemic within these facilities are in the best position to make policy recommendations for the future that the AMA can advocate on their behalf. Your Reference Committee agrees with the opinion of the Council and believes that this amended language will still allow for collaboration with stakeholders. Therefore, your Reference Committee recommends that Resolution 407 be adopted as amended.

- (9) RESOLUTION 411 – ONGOING USE OF MASKS BY AND AMONG HIGH-RISK INDIVIDUALS TO REDUCE THE RISK OF SPREAD OF RESPIRATORY PATHOGENS

RECOMMENDATION A:

That the first Resolve of Resolution 411 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support endorse the ongoing use of face masks for ~~all~~ those wishing to protect themselves and those around them from ~~reduce the risk of~~ respiratory tract infections ~~during the time of year when respiratory pathogens are most likely to circulate and whenever respiratory infections are known to be circulating when people are in close contact and indoors~~ (Directive to Take Action);

RECOMMENDATION B:

Resolution 411 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 411 be changed to read as follows:

USE OF FACE MASKS BY INDIVIDUALS TO REDUCE THE SPREAD OF RESPIRATORY PATHOGENS

HOD ACTION: Resolution 411 adopted as amended with change in title to read as follows:

USE OF FACE MASKS BY INDIVIDUALS TO REDUCE THE SPREAD OF RESPIRATORY PATHOGENS

RESOLVED, That our American Medical Association endorse the use of masks for all those wishing to reduce the risk of respiratory tract infection during the time of year when respiratory pathogens are most likely to circulate and whenever respiratory infections are known to be circulating when people are in close contact and indoors (Directive to Take Action); and be it further

RESOLVED, That our AMA promulgate scientific information to both patients and physicians about the benefits of masks to protect patients, especially those at high risk, to reduce exposure to and spread of respiratory pathogens. (Directive to Take Action)

Your Reference Committee heard testimony overwhelmingly supportive of Resolution 411. It was noted by many who testified that the impact of wearing face masks on the transmission of COVID-19 has been profound, and that many individuals will still wish to wear masks even if local masking guidelines are rescinded. Several who testified noted the benefits of mask-wearing for other respiratory infection, such as influenza, and that mask-wearing has been normalized in other countries. Your Reference Committee felt that the proposed language of the Resolution could be expanded to support all scenarios in which an individual wishes to wear a face mask to protect themselves and those around them, at any time of year. Therefore, your Reference Committee recommends that Resolution 411 be adopted as amended.

- (10) RESOLUTION 414 – CALL FOR IMPROVED PERSONAL PROTECTIVE EQUIPMENT DESIGN AND FITTING

RECOMMENDATION A:

Resolution 414 be amended by addition to read as follows:

RESOLVED, That our American Medical Association encourage the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel workers. (Directive to Take Action)

RECOMMENDATION B:

Resolution 414 be adopted as amended.

HOD ACTION: Resolution 414 adopted as amended.

RESOLVED, That our American Medical Association encourage the diversification of personal protective equipment design to better fit all body types among healthcare workers. (Directive to Take Action)

Your Reference Committee heard testimony in strong support of Resolution 414. Testimony emphasized the need for diversification of PPE sizes to accommodate varying body types, including consideration around cultural expressions and practices, to facilitate safer working environments for all health care personnel. Therefore, your Reference Committee recommends that Resolution 414 be adopted as amended.

- (11) RESOLUTION 415 – AMENDING H-440.847 TO CALL FOR NATIONAL GOVERNMENT AND STATES TO MAINTAIN PERSONAL PROTECTIVE EQUIPMENT AND MEDICAL SUPPLY STOCKPILES

RECOMMENDATION A:

Resolution 415 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend Policy H-440.847 by addition and deletion to read as follows:

Pandemic Preparedness ~~for Influenza~~ H-440.847

In order to prepare for a ~~potential influenza~~ **pandemic**, our AMA:

- (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to an ~~influenza a pandemic~~ or other serious public health emergency;
- (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), ~~the Strategic National Stockpile~~ and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, and anti-viral microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people, without overreliance on unreliable international sources of production; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for ~~and respond to, and protect the population from illness and death in an influenza a pandemic~~ or other serious public health emergency;
- (3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;
- (4) urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency;
- (35) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of health care personnel physicians and medical office staff in ambulatory direct patient care settings;
- (46) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) continue take immediate action to plan and test distribution activities in advance of a public health emergency, to assure that physicians, nurses, other health care ~~personnel professionals~~ professionals, and first responders having direct patient contact, receive any appropriate vaccination or medical countermeasure in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such

pandemic, what the plan will be to provide immunization to health care provider;

(7) will monitor progress in developing a contingency plan that addresses future ~~influenza~~-vaccine production or distribution problems and in developing a plan to respond to an ~~influenza~~ pandemic in the United States. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 415 be adopted as amended.

HOD ACTION: Resolution 415 adopted as amended.

RESOLVED, That our American Medical Association amend policy H-440.847 by addition and deletion to read as follows:

Pandemic Preparedness ~~for Influenza~~ H-440.847

In order to prepare for a ~~potential influenza~~ pandemic, our AMA:

(1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to an ~~influenza~~ a pandemic or other serious public health emergency;

(2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), ~~the Strategic National Stockpile~~ and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, and anti-viral microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to, and protect the population from illness and death in an influenza a pandemic or other serious public health emergency;

(3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;

(4) urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency;

(~~3~~5) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an ~~influenza~~ epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings;

(~~4~~6) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers;

(7) will monitor progress in developing a contingency plan that addresses future ~~influenza~~-vaccine production or distribution problems and in developing a plan to respond to an ~~influenza~~ pandemic in the United States. (Modify Current HOD Policy)

Your Reference Committee heard testimony that supported the goals reflected in Resolution 415. There was unanimous agreement surrounding the broadening of policy to reflect pandemic environments rather than narrowly addressing influenza pandemics. Testimony acknowledged the need to improve the availability of medical equipment and supplies in a pandemic, while reflecting on the utility of this policy during critical actions related to the COVID-19 pandemic last year. Select testimony urged the need to call attention toward more explicit action in accessing stockpiles, citing the difficulty in obtaining adequate amounts of PPE during COVID-19 surges as evidence. The USPHS suggested amended language that recognizes healthcare personnel and direct patient care

settings as well as ensuring planning and testing of distribution models. Your Reference Committee agrees with these suggestions and recommends that Resolution 415 be adopted as amended.

(12) RESOLUTION 421 – MEDICAL MISINFORMATION IN THE AGE OF SOCIAL MEDIA

RECOMMENDATION A:

That the first Resolve of Resolution 421 be amended by addition to read as follows:

RESOLVED, That our AMA encourage social media companies and organizations to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; and be it further

RECOMMENDATION B:

That the second Resolve of Resolution 421 be amended by addition to read as follows:

RESOLVED, That our AMA encourage social media companies and organizations to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; and be it further

RECOMMENDATION C:

That the third Resolve of Resolution 421 be amended by addition to read as follows:

RESOLVED, That our AMA continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and be it further

RECOMMENDATION D:

That the fourth Resolve of Resolution 421 be amended by addition to read as follows:

RESOLVED, That our AMA work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information; and be it further

RECOMMENDATION E:

That the fifth Resolve of Resolution 421 be amended by addition to read as follows:

RESOLVED, That our AMA amend existing policy concerning COVID-19 vaccine information to increase its scope and impact regarding medical misinformation as follows:

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

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online.; and be it further

RECOMMENDATION F:

That the sixth Resolve of Resolution 421 be referred for decision.

RECOMMENDATION G:

Resolution 421 be adopted as amended.

RECOMMENDATION H:

That the title of Resolution 421 be changed to read as follows:

MEDICAL AND PUBLIC HEALTH MISINFORMATION IN THE AGE OF SOCIAL MEDIA

HOD ACTION: Resolution 421 adopted as amended with change in title to read as follows:

MEDICAL AND PUBLIC HEALTH MISINFORMATION IN THE AGE OF SOCIAL MEDIA

RESOLVED, That our AMA encourage social media organizations to further strengthen their content moderation policies related to medical misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; and be it further

RESOLVED, That our AMA encourage social media organizations to recognize the spread of medical misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; and be it further

RESOLVED, That our AMA continue to support the dissemination of accurate medical information by public health organizations and health policy experts; and be it further

RESOLVED, That our AMA work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical information; and be it further

RESOLVED, That our AMA amend existing policy concerning COVID-19 vaccine information to increase its scope and impact regarding medical misinformation as follows:

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

Our AMA will institute a program to promote the integrity of a COVID-19 ~~vaccination~~ information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online.; and be it further

RESOLVED, That our AMA study and consider public advocacy of modifications to Section 230(c) of the Communications Decency Act, Part 2, Clause A, as follows:

any action voluntarily taken in good faith to restrict access to or availability of material that the provider or user considers to be obscene, lewd, lascivious, excessively violent, harassing, pose risk to public health, or be otherwise objectionable, whether or not such material is constitutionally protected.

Your Reference Committee heard testimony in strong support of the intent of Resolution 421. The importance of disseminating accurate information was echoed by several members due to the burden misinformation across social media platforms places on physicians. It was also noted that misinformation leads to patient harm. Those who commented noted that the subject of misinformation should be broadened beyond just medical information to also encompass public health information; to allow better support of our colleagues that work in public health agencies. Additionally, since social media organizations are often referred to as “companies,” Your Reference Committee also added this term to the new policy to ensure clarity. The Council on Science and Public Health supported referral for decision of the last resolve because of the complexity around establishing and implementing a public health exception to the Communications Decency Act and Your Reference Committee agrees. Therefore, your Reference Committee recommends that the first five Resolves of Resolution 421 be adopted as amended and the last Resolve be referred for decision.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (13) RESOLUTION 402 – MODERNIZATION AND STANDARDIZATION OF PUBLIC HEALTH SURVEILLANCE SYSTEMS

RECOMMENDATION A:

Alternate Resolution 402 be adopted lieu of Resolution 402.

That our American Medical Association: (1) advocate for increased federal coordination and funding to support the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments and (2) support data standardization that provides for minimum national standards, while preserving the ability of states

and other entities to exceed national standards based on local needs and/or the presence of unexpected urgent situations.

RECOMMENDATION B:

That Policy H-440.813, “Public Health Surveillance,” be reaffirmed.

HOD ACTION: Alternate Resolution 402 adopted and Policy H-440.813 reaffirmed.

RESOLVED, That our American Medical Association advocate for the modernization and standardization of public health surveillance systems data collection by the Centers for Disease Control and Prevention and state and local health departments, including but not limited to increased federal coordination and funding. (Directive to Take Action)

Your Reference Committee heard testimony in support of the intent of Resolution 402. However, the Council on Science and Public Health noted that they developed existing policy addressing the modernization of public health data and surveillance systems at the 2019 Interim Meeting and the AMA has been advocating for sustainable funding in support of the CDC’s Data Modernization Initiative. Your Reference Committee agrees that strong policy already exists in support of funding for data modernization but felt that AMA policy could be strengthened around coordination and the development of national standards for public health data. As a result, Your Reference Committee proposes the adoption of alternate language as provided by the CDC and public health physicians in testimony to address these areas as well as the reaffirmation of existing policy on public health surveillance.

H-440.813, “Public Health Surveillance”

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.

- (14) RESOLUTION 410 – ENSURING ADEQUATE HEALTH CARE RESOURCES TO ADDRESS THE LONG COVID CRISIS
RESOLUTION 413 – CALL FOR INCREASED FUNDING AND RESEARCH FOR POST VIRAL SYNDROMES

RECOMMENDATION A:

Alternate Resolution 410 be adopted in lieu of Resolutions 410 and 413.

CALL FOR INCREASED FUNDING, RESEARCH, AND EDUCATION FOR POST VIRAL SYNDROMES

RESOLVED, That our American Medical Association support the development of an ICD-10 code or family of codes to recognize Post-Acute Sequelae of SARS-CoV-2 infection (“PASC” or “Long COVID”) and other novel post-viral syndromes as distinct diagnoses (New HOD Policy); and be it further

RESOLVED, That our American Medical Association advocate for legislation to provide funding for research, prevention, control, and treatment of post viral syndromes and long-term sequelae associated with viral infections, such as COVID-19 (Directive to Take Action); and be it further

RESOLVED, That our AMA provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequelae associated with viral infections, such as COVID-19 (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequelae associated with viral infections, such as COVID-19, to minimize the harm and disability current and future patients face. (Directive to Take Action)

HOD ACTION: Alternate Resolution 410 adopted in lieu of Resolutions 410 and 413 with change in title to read as follows:

CALL FOR INCREASED FUNDING, RESEARCH, AND EDUCATION FOR POST VIRAL SYNDROMES

RESOLVED, That our American Medical Association support the development of an ICD-10 code or family of codes to recognize Post-Acute Sequelae of SARS-CoV-2 infection (“PASC” or “Long COVID”) as a distinct diagnosis (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the development of immediate and long-term strategies for funding and research to address equitable access to appropriate clinical care for all individuals experiencing PASC (Directive to Take Action); and be it further

RESOLVED, That our AMA disseminate up-to-date information to physicians regarding best practices to mitigate the effects of PASC in a timely manner. (Directive to Take Action)

RESOLVED, That our American Medical Association advocate for legislation to provide funding for research, prevention, control, and treatment of post viral syndromes and long-term sequelae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue (ME/CFS) (Directive to Take Action); and be it further

RESOLVED, That our AMA provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequelae associated with COVID-19, including, but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequelae associated with COVID-19, including but not limited to Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), to minimize the harm and disability current and future patients face. (Directive to Take Action)

Your Reference Committee heard thoughtful and thorough testimony related to Resolutions 413 and 410, with a majority supporting the merging of the resolutions to support funding for research and the dissemination of educational resources on post viral syndromes, particularly Long COVID-19 and Post-Acute Sequelae of SARS-CoV-2 (PASC). Testimony emphasized the need to improve the clinical definition(s) of post viral syndromes and identify the evidence necessary to appropriately assess all conditions and organ systems affected as well as the associated behavioral health conditions. Your Reference Committee is also aware that efforts to develop an ICD-10 code for these syndromes are already well underway, but felt the AMA having a policy statement in support of the

activity may be helpful. Therefore, your Reference Committee recommends that Alternate Resolution 410 be adopted in lieu of Resolution 410 and Resolution 413.

- (15) RESOLUTION 420 – IMPACT OF SOCIAL NETWORKING SERVICES ON THE HEALTH OF ADOLESCENTS

RECOMMENDATION A:

That Policy D-478.965, “Addressing Social Media Usage and its Negative Impacts on Mental Health,” be amended by addition and deletion in lieu of Resolution 420 to read as follows:

Addressing Social Media and Social Networking Usage and its Negative Impacts on Mental Health

Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the development of continuing education programs to enhance physicians’ knowledge of the health impacts of social media and social networking usage; and (b) support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage; ~~and~~ (2) advocates for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage; (3) affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions; (4) advocates for and support media and social networking services addressing and developing safeguards for users; and (5) advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use.

RECOMMENDATION B:

Policy D-478.965 be adopted as amended.

HOD ACTION: Policy D-478.965 adopted as amended in lieu of Resolution 420

RESOLVED, That our American Medical Association affirm that use of social networking services has the potential to negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions, and therefore these services should have established, evidence-based, reliable safeguards to protect vulnerable populations from harm (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the study of the biological, psychological, and social effects of social networking services use, and to advocate for legislative or regulatory action, including the expansion of Children’s Online Privacy Protection Act of 1998 protections, to mitigate the potential harm from the use of social networking services to adolescents and other vulnerable populations. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 420. Testimony noted that Our AMA currently has policy related to the impact of social media on mental health. Testimony highlighted that there are both positive and negative effects associated with social media use, and that this should be reflected in AMA policy. Amendments were proffered to improve both the resolution and the existing policy, as the reliance on and impact of social media has increased during the ongoing pandemic. Additionally, there was confusion around the second Resolve, which is both calling for a study and for legislative or regulatory action. Your Reference Committee believes the best way to support this item is by amending current AMA policy to include the new concepts introduced in the resolution. Your

Reference Committee also included the term “social media” along with “social networking services” as it is broader and would be inclusive of all services. Your Reference Committee has included clauses calling for AMA advocacy related to the development of safeguards by social media and social network services and to support groups studying both the positive and negative biological, psychological, and social effects of social media and social networking services. Therefore, your Reference Committee recommends that Policy D-478.965 be adopted as amended.

RECOMMENDED FOR REFERRAL

- (16) RESOLUTION 401 – UNIVERSAL ACCESS FOR ESSENTIAL PUBLIC HEALTH SERVICES

RECOMMENDATION A:

That the first Resolve of Resolution 401 be referred with report back at the next AMA HOD meeting.

RECOMMENDATION B:

That the second Resolve of Resolution 401 be adopted.

HOD ACTION: That the first Resolve of Resolution 401 referred with report back at the next AMA HOD meeting and the second Resolve of Resolution 401 referred.

RESOLVED, That our American Medical Association study the options and/or make recommendations regarding the establishment of:

1. A list of all essential public health services that should be provided in every jurisdiction of the United States;
2. A nationwide system of information sharing and intervention coordination in order to effectively manage nationwide public health issues;
3. A federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services;
4. A federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction (Directive to Take Action); and be it further

RESOLVED, That our AMA prepare and publicize annual reports on current efforts and progress to achieve universal access to all essential public health services. (Directive to Take Action)

Your Reference Committee heard testimony supportive of the intent of Resolution 401, which is to strengthen our nation’s public health system for all people in all communities. It was noted in testimony by the Council on Science and Public Health and by the Department of Health and Human Services that the AMA recently participated in the task force that developed the revised 10 Essential Public Health Services released in September of 2020. If the AMA were to study the establishment of such a list, the AMAs recent work and ongoing support of the revised 10 Essential Public Health Services would be called into question and result in confusion. Your Reference Committee agrees and is not suggesting that the AMA create its own list of essential public health services. However, the Council on Science and Public Health is currently studying effective ways to strengthen the nation’s public health infrastructure, as directed by the House of Delegates in November 2020. The Council’s report, which will be informed by key stakeholder interviews, is due back to the House of Delegates in November of 2021. Your Reference Committee agrees that the first Resolve is best accomplished by referral for consideration by the Council in their upcoming report, with report back for November 2021. However, your Reference Committee believes that the second Resolve, which calls on the AMA to provide annual reports on access to essential public health services should be adopted.

RECOMMENDED FOR REFERRAL FOR DECISION

- (17) RESOLUTION 403 – CONFRONTING OBESITY AS A KEY CONTRIBUTOR TO MATERNAL MORTALITY, RACIAL DISPARITY, DEATH FROM COVID-19, UNAFFORDABLE HEALTH CARE COST WHILE RESTORING HEALTH IN AMERICA

RECOMMENDATION:

Resolution 403 be referred for decision.

HOD ACTION: Resolution 403 referred for decision.

RESOLVED, That our American Medical Association advocate for a National Task Force to be led by the medical profession along with other stakeholders to confront the epidemic of obesity primarily among minority women, prior to, during and after pregnancy, thereby reducing maternal mortality & morbidity rates, racial disparity in access to care, death from COVID-19 infection and healthcare costs while restoring health in our nation with report back at the 2021 Interim Meeting and beyond. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 403. Some supported forming a national task force to address obesity, while others testified that the maternal morbidity and mortality crisis is too multifaceted to adequately be captured by effects of obesity. It was noted in online testimony that the way the resolution is written, while not intentional, might be interpreted as blaming minority women for being obese and that any task force created should evaluate and address the root causes of obesity. Others spoke in favor of referral due to the need for evidence-based reframing of the original resolution.

Additional testimony noted there is confusion as to whether said National Task Force would be created and led by our AMA, or if our AMA would advocate for the creation of a task force of which it would be a stakeholder. The Council on Science and Public Health noted that they are working on a series of reports with the Council on Medical Service to address maternal health, with the first report expected in November of 2021. Due to the confusion around this resolution and the extensive work already underway at the AMA, your Reference Committee recommends referral for decision to determine the best path forward.

REPORT OF REFERENCE COMMITTEE E

RECOMMENDED FOR ADOPTION AS AMENDED

- (1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 – USE OF DRUGS TO CHEMICALLY RESTRAIN AGITATED INDIVIDUALS OUTSIDE OF HOSPITAL SETTINGS

RECOMMENDATION A:

Recommendation 1 in Council on Science and Public Health Report 2 be amended by addition and deletion to read as follows:

1. That the following new AMA policy be adopted:
~~Use of Drugs to Chemically Restrain Agitated Individuals Outside of Hospital Settings~~ Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting

Our American Medical Association:

1. Believes that current evidence does not support “excited delirium” or “excited delirium syndrome” as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated;
2. Recognizes that the treatment of medical emergency conditions outside of a hospital is usually done by a subset of healthcare practitioners who are trained and have expertise as emergency medical service (EMS) practitioners. It is vital that EMS practitioners and systems are overseen by physicians who have specific experience and expertise in providing EMS medical direction.
3. Is concerned about law enforcement officer use of force accompanying “excited delirium” that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces “excited delirium” solely as a justification for the use of force by law enforcement officers.
4. Opposes the use of sedative/hypnotic and dissociative agents, including ketamine, as a pharmacological intervention for agitated individuals in the out-of-hospital setting, when done to chemically restrain an individual solely for a law enforcement purpose and not for a legitimate medical reason;
5. Recognizes that sedative/hypnotic and dissociative pharmacological interventions for agitated individuals drugs for chemical restraint used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of age, underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken;
6. Calls for comprehensive reviews, performed by independent investigators including appropriate medical and behavioral health professionals, of law enforcement agencies and emergency medical service agencies to:
 - a. Investigate any cases labeled as “excited delirium” for disproportionate application of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors;

- b. Evaluate the prevalence of ketamine use in the field in unmonitored individuals;
 - c. Assess that comprehensive training and guidelines, including continuous quality improvement processes, have been properly established by supervising EMS medical directors and behavioral health specialists, to:
 - i. Require appropriate monitoring of any patient who receives sedative/hypnotic and dissociative pharmacological interventions for treatment in the out-of-hospital setting;
 - ii. Ensure proper use of ketamine and other sedative/hypnotic and dissociative pharmacological interventions under defined protocols/guidelines after appropriate education on indications, usage and complications;
 - iii. Include an appropriate stepwise approach to the treatment of patients in the out-of-hospital setting, including de-escalation training, that provides safety to the patient and providers;
 - d. Ensure that appropriate financial support by local and/or state agencies for training and reporting is available; and
 - e. ~~are appropriate, and include de-escalation training; and~~
 - f. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training ~~to ensure patient safety;~~
7. Urges law enforcement and frontline emergency medical service personnel, who are a part of the “dual response” in emergency situations, to participate in appropriate training ~~that, overseen by EMS medical directors. The training should~~ minimally includes de-escalation techniques and the appropriate use of pharmacological intervention for agitated individuals in the out-of-hospital setting ~~drugs used to restrain individuals; and~~
8. Urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in the out-of- a non-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way. (New HOD Policy)

RECOMMENDATION B:

The recommendations in Council on Science and Public Health Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION:

Recommendation 1, subsection 6 referred for decision.

All other Recommendations in Council on Science and Public Health Report 2 adopted as amended and the remainder of the report filed.

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

1. That the following new AMA policy be adopted:

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

Our American Medical Association:

1. Believes that current evidence does not support “excited delirium” or “excited delirium syndrome” as a medical diagnosis and opposes the use of the terms until a clear set of diagnostic criteria are validated;
 2. Is concerned about law enforcement officer use of force accompanying “excited delirium” that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces “excited delirium” solely as a justification for the use of force by law enforcement officers.
 3. Opposes the use of sedative/hypnotic agents, including ketamine, to chemically restrain an individual solely for a law enforcement purpose;
 4. Recognizes that drugs for chemical restraint used outside of a hospital setting by non-physicians have significant risks intrinsically, in the context of underlying medical conditions, and also related to potential drug-drug interactions with agents the individual may have taken;
 5. Calls for comprehensive reviews, performed by independent investigators including appropriate medical and behavioral health professionals, of law enforcement agencies and emergency medical service agencies to:
 - a. Investigate any cases labeled as “excited delirium” for disproportionate application of the term, including prevalence of its use by race, ethnicity, gender, age, and other demographic factors;
 - b. Evaluate the prevalence of ketamine use in the field in unmonitored individuals;
 - c. Assess that training and guidelines have been properly established by supervising medical and behavioral health specialists, are appropriate, and include de-escalation training; and
 - d. Assess, on an ongoing basis, that personnel are conducting themselves according to guidelines and training to ensure patient safety; and
 6. Urges law enforcement and emergency medical service personnel to participate in appropriate training that minimally includes de-escalation techniques and the appropriate use of drugs used to restrain individuals; and
 7. Urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in a non-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way. (New HOD Policy)
2. That Policy H-65.954, “Policing Reform,” which recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color, notes AMA’s willingness to work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers, states that AMA will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures, and will advocate for legislation and regulations which promote trauma-informed, community-based safety practices, be reaffirmed. (Reaffirm Current AMA Policy)
 3. That Policy H-345.972, “Mental Health Crisis Interventions,” which supports jail diversion and community based treatment options for mental illness, implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs, federal funding to encourage increased community and law enforcement participation in crisis intervention training programs, and legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities, be reaffirmed. (Reaffirm Current AMA Policy)

Your Reference Committee heard passionate testimony about CSAPH Report 2. Many who testified applauded the evidence-based review of the controversial topic and are proud that the AMA has taken a stance on this issue which is a representation of systemic racism in medicine. Several commentors noted that delirium is very much an acute psychiatric condition as clearly defined in the DSM-5 and its specifiers do not include “excited;” this unfortunate term has been misapplied to individuals who are agitated in the community for a multitude of reasons. Many commenters agreed that it is concerning that it disproportionately impacts individuals of color, for whom inappropriate and excessive pharmacotherapy continues to be the norm instead of behavioral de-escalation.

Several commentors were emergency physicians and EMS medical directors and expressed concerns about the report recommendations. Notably that the proposed recommendations did not adequately capture a physician-led approach for emergency response for individuals experiencing delirium. In addition, concerns were raised that physicians and law enforcement were being requested to undergo similar training regimens that may not be appropriate for their roles. In rebuttal, other commentors noted that emergency response typically utilizes a “dual response” method of law enforcement and first responders, indicating that a combined or complimentary training approach may be appropriate. Further concerns were raised about the oversight authority for investigating potential cases in which inappropriate pharmacological intervention was suspected. CSAPH believes that independent investigators were appropriate, whereas members of the emergency medicine community believe that EMS Medical Directors should lead any authority, with a supporting consortium providing guidance. Finally, many emergency medicine practitioners commented that they disagree with their colleagues and believe that “excited delirium” is an appropriate diagnosis and one commentor noted that they worry there could be legal ramifications if the diagnosis is deemed invalid. Your Reference Committee agrees with the majority of testimony that current evidence does not support “excited delirium” as a diagnosis.

Several amendments to the CSAPH recommendations were offered. CSAPH noted in testimony that they appreciate the input and amendments proffered by our emergency medicine colleagues and concur with many of the amendments, including the title change which aligns with the Joint Commission preferred verbiage, the use of the term pharmacological intervention, the addition of age as a risk factor, and a newly added recommendation which highlights and recognizes the important work of EMS Medical Director physician colleagues and reiterates long standing policy of physician oversight, supervision, and leadership of the health care team, in all forms of settings including the out of the hospital setting. CSAPH, however, prefers the language of their original report recommendations for other items, as they think it hems closer to the findings in the body of the report and maintains its initial focus on the topic that the BOT asked them to review.

Your Reference Committee agrees with the perspective that independent oversight is important to evaluate this issue, but also understand the need for physician oversight of frontline EMS personnel. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 2 be adopted as amended.

(2) RESOLUTION 503 – ACCESS TO EVIDENCE-BASED ADDICTION TREATMENT IN CORRECTIONAL FACILITIES

RECOMMENDATION A:

The first Resolve of Resolution 503 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend policy H-430.987, “Opiate Replacement Therapy Programs in Correctional Facilities,” by addition and deletion to read as follows:

Opiate Replacement Therapy Programs Medications for Opioid Use Disorder in Correctional Facilities H-430.987

1. Our AMA endorses: (a) the medical treatment model of employing opiate replacement therapy (ORT) medications for opioid use disorder (OUD) as an effective therapy in treating opiate-addicted the standard of care for persons with OUD who are incarcerated; and (b) ORT for opiate-addicted medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to, the National Commission on Correctional Health Care and the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.

2. Our AMA advocates for legislation, standards, policies and funding that encourage require correctional facilities to increase access to evidence-based treatment of OUD opiod use disorder, including initiation and continuation of opiod replacement therapy medications for OUD, in conjunction with counseling psychosocial treatment when

~~available and~~ desired by the person with OUD, in correctional facilities within the United States and that this apply to all ~~incarcerated~~ individuals who are incarcerated, including pregnant women individuals who are pregnant, postpartum, or parenting.

3. Our AMA ~~supports~~ advocates for legislation, standards, policies, and funding that ~~encourage~~ require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD ~~opioid use disorder~~, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment including medications for addiction treatment medication-assisted therapy.

4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.
(Modify Current HOD Policy)

RECOMMENDATION B:

The second Resolve of Resolution 503 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA amend policy H-430.986, "Health Care While Incarcerated," by addition and deletion to read as follows:

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~~ advocates and requires a smooth transition including 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~~ advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

~~6. Our AMA urges advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons, 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 Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.~~

~~8.7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females who are incarcerated, including gynecological care and obstetrics care for pregnant and postpartum women individuals who are pregnant or postpartum.~~

~~9.8. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both inmates individuals who are incarcerated and staff in correctional facilities.~~

~~10.9. 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.~~

~~11. Our American Medical Association advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention (Directive to Take Action).~~

~~12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities (Directive to Take Action).~~

(Modify Current HOD Policy)

RECOMMENDATION C:

Resolution 503 be adopted as amended.

HOD ACTION: Resolution 503 adopted as amended.

RESOLVED, That our American Medical Association amend policy H-430.987, “Opiate Replacement Therapy Programs in Correctional Facilities,” by addition and deletion to read as follows:

Opiate Replacement Therapy Programs Medications for Opioid Use Disorder in Correctional Facilities H-430.987

1. Our AMA endorses: (a) the medical treatment model of employing opiate replacement therapy (ORT) medications for opioid use disorder (OUD) as an effective therapy in treating opiate addicted the standard of care for

persons with OUD who are incarcerated; and (b) ~~ORT for opiate-addicted medications for persons with OUD~~ who are incarcerated, an endorsement in collaboration with ~~the National Commission on Correctional Health Care and~~ the American Society of Addiction Medicine.

2. Our AMA advocates for legislation, standards, policies and funding that ~~encourage~~ require correctional facilities to increase access to evidence-based treatment of OUD ~~opioid use disorder~~, including initiation and continuation of ~~opioid replacement therapy~~ medications for OUD, in conjunction with ~~counseling~~ psychosocial treatment when available and desired by the person with OUD, in correctional facilities within the United States and that this apply to all ~~incarcerated~~ individuals who are incarcerated, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting.

3. Our AMA ~~supports~~ advocates for legislation, standards, policies, and funding that ~~encourage~~ require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including ~~pregnant women~~ individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD ~~opioid use disorder~~, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, including medications for addiction treatment medication-assisted therapy.

4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-430.986, “Health Care While Incarcerated,” by addition and deletion to read as follows:

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~~ advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal ~~justice~~ legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA ~~urges~~ advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons, ~~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 Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.

~~8.7.~~ Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of ~~incarcerated~~ women and adolescent females who are incarcerated, including gynecological care and obstetrics care for ~~pregnant and postpartum women~~ individuals who are pregnant or postpartum.

~~9.8.~~ Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both inmates individuals who are incarcerated and staff in correctional facilities.

10.9. 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. (Modify Current HOD Policy)

Your Reference Committee heard testimony unanimously supportive of this Resolution. Several amendments were proposed to clarify some of the language in the policy and these amendments were roundly supported. An amendment was proposed to expand the policy to cover individuals held in pre-trial detention and to advocate for the prohibition of co-pays in correctional facilities. No testimony was opposed to the amendments offered. Your Reference Committee notes that while the title of this resolution would suggest these additional amendments would be limited to substance use disorder treatment, the proposed resolution is amending current AMA policy that affects all medical treatment within a correctional facility. Your Reference Committee agrees with testimony that this Resolution provides important updates for AMA policy and therefore, recommends that Resolution 503 be adopted as amended.

REPORT OF REFERENCE COMMITTEE F

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 3 - AMA 2022 DUES

RECOMMENDATION:

Recommendation in Board of Trustees Report 3 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 3 adopted and the remainder of the Report filed.

The Board of Trustees recommends no change to the dues levels for 2022, that the following be adopted and that the remainder of this report be filed.

Regular Members	\$ 420
Physicians in Their Fourth Year of Practice	\$ 315
Physicians in Their Third Year of Practice	\$ 210
Physicians in Their Second Year of Practice	\$ 105
Physicians in Their First Year of Practice	\$ 60
Physicians in Military Service	\$ 280
Semi-Retired Physicians	\$ 210
Fully Retired Physicians	\$ 84
Physicians in Residency Training	\$ 45
Medical Students	\$ 20

(Directive to Take Action)

Your Reference Committee received no testimony in response to Board of Trustees Report 3.

Our AMA Board of Trustees is recommending no changes from prior years in the 2022 standard dues rates and highlighted that the last time our AMA raised dues was in 1994. It was stated that had our AMA adjusted dues over the past 27 years to remain on pace with inflation, current annual dues for regular members would be \$725.

- (2) BOARD OF TRUSTEES REPORT 12 – ADOPTING THE USE OF THE MOST RECENT AND UPDATED EDITION OF THE AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT

RECOMMENDATION:

Recommendation in Board of Trustees Report 12 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 12 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 606-NOV-20 and the remainder of this report be filed:

Support for the Use of the Most Recent and Updated Edition of the *AMA Guides to the Evaluation of Permanent Impairment*.

Our American Medical Association supports the adoption of the most current edition of the *AMA Guides to the Evaluation of Permanent Impairment* by all jurisdictions to provide fair and consistent impairment evaluations for patients and claimants including injured workers. (New HOD Policy)

Testimony received for Board of Trustees Report 12 was limited, but largely favorable.

Our AMA Board of Trustees testified that the report speaks to the fact that the AMA Guides previously were published at inconsistent intervals and typically involved significant changes to methodology. They were last updated in 2008 when the 6th edition was released, though some states have elected to continue use of outdated medicine in older editions of the AMA Guides for convenience, ease of use, or political/economic expedience. The report also highlights our AMA's establishment of a new editorial panel and process that support ongoing incremental improvement to the AMA Guides.

Some opposing views indicated that the AMA Guides are not peer-reviewed; however, your Reference Committee notes that the resource is peer-created. Additionally, some speakers favored flexibility on which edition to use and advocated for freedom of choice. To address this concern, your Reference Committee believes it would be beneficial to provide electronic access to older versions of the AMA Guides to facilitate flexibility in use.

- (3) JOINT REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS AND THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 – JOINT COUNCIL SUNSET REVIEW OF 2011 HOUSE POLICIES

RECOMMENDATION:

Recommendation in Joint Report of the Council on Constitution and Bylaws and the Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Joint Report of the Council on Constitution and Bylaws and the Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

The Councils on Constitution and Bylaws and Long Range Planning and Development recommend that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee wishes to extend its appreciation to the Councils on Constitution and Bylaws and Long Range Planning and Development for their report. Having received no testimony in response to the report, your Reference Committee supports the Councils' recommendations.

RECOMMENDED FOR ADOPTION AS AMENDED

- (4) RESOLUTION 602 – TIMELY PROMOTION AND ASSISTANCE IN ADVANCE CARE PLANNING AND ADVANCE DIRECTIVES

RECOMMENDATION A:

Resolution 602 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association begin a low cost in-house educational effort aimed at physicians, to include relevant billing and reimbursement information, encouraging physicians to lead by example and complete their own advance directives (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage practicing physicians to voluntarily publicize the fact of having executed our own advance directives, and to share readily available educational materials regarding the importance and components of advance directives in offices and on practice websites, as a way of starting the conversation with patients and families (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA strongly encourage all ~~primary care~~ physicians of relevant specialties providing primary or/and advanced illness care to include advance care planning as a routine part of their adult patient care protocols when indicated, and also to include including advance directive documentation in patients' medical records (including electronic medical records), as a suggested standard health maintenance practice (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA collaborate (prioritized and made more urgent by the ongoing COVID-19 pandemic) with stakeholder groups, such as legal, medical, hospital, medical education, and faith-based communities as well as interested citizens, to promote completion of advance directives by all individuals who are of legal age and competent to make healthcare decisions, and to promote the adoption and use of electronic systems to make patients' advance directives readily available to treatment teams regardless of location (Directive to Take Action); and be it further

RESOLVED, That our AMA actively promote the officially recognized designation of April 16 as National Healthcare Decisions Day. (New HOD Policy)

RECOMMENDATION B:

Resolution 602 be adopted as amended.

HOD ACTION: Resolution 602 adopted as amended

RESOLVED, That our American Medical Association begin a low cost in-house educational effort aimed at physicians, to include relevant billing and reimbursement information, encouraging physicians to lead by example and complete their own advance directives (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage practicing physicians to voluntarily publicize the fact of having executed our own advance directives, and to share readily available educational materials regarding the importance and components of advance directives in offices and on practice websites, as a way of starting the conversation with patients and families (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA strongly encourage all primary care physicians to include advance care planning as a routine part of their adult patient care protocols, and also to include advance directive documentation in patients' medical records as a suggested standard health maintenance practice (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA collaborate (prioritized and made more urgent by the ongoing COVID-19 pandemic) with stakeholder groups, such as legal, medical, hospital, medical education, and faith-based communities as well as interested citizens, to promote completion of advance directives by all individuals who are of legal age and competent to make healthcare decisions (Directive to Take Action); and be it further

RESOLVED, That our AMA actively promote the officially recognized designation of April 16 as National Healthcare Decisions Day. (New HOD Policy)

Testimony received for Resolution 602 was overwhelmingly supportive. Speakers noted that physicians, family members, and caregivers often face an ethical dilemma when the patient is unable to communicate their wishes for medical treatment. The COVID-19 pandemic has underscored the need for advance directives, particularly in light of hospital isolation requirements.

Further, testimony noted that advance care planning should not be limited to adult patients as there may be instances when an advanced directive for pediatric patients may be required. Speakers also noted that physicians of varying specialties, in addition to primary care physicians, could be instrumental in advising their patients on preparing advanced directives.

Additionally, testimony supported the use of electronic systems (e.g., electronic medical records, cloud-based storage, etc.) to make advance directives more readily available. Your Reference Committee concurs and recommends that Resolution 602 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(5) RESOLUTION 608 – SHARING COVID-19 RESOURCES

RECOMMENDATION:

Alternate Resolution 608 be adopted in lieu of Resolutions 608, 609, 610, and 611.

HOD ACTION: Alternate Resolution 608 adopted in lieu of Resolutions 608, 609, 610, and 611.

PROMOTING EQUITABLE RESOURCE DISTRIBUTION GLOBALLY IN RESPONSE TO THE COVID-19 PANDEMIC

RESOLVED, That our AMA, in an effort to improve public health and national stability, explore possible assistance through the COVID-19 Vaccines Global Access (COVAX) initiative co-led by the World Health Organization, Gavi, and the Coalition for Epidemic Preparedness Innovations, as well as all other relevant organizations, for residents of countries with limited financial or technological resources ~~where the cases of COVID-19 infection have been exponentially increasing~~ (Directive to Take Action); and be it further

RESOLVED, That our AMA will work with governmental and appropriate regulatory bodies to encourage prioritization of equity when providing COVID-19 pandemic-related resources, such as diagnostics, low cost or free medications, therapeutics, vaccines, raw materials for vaccine production, personal protective equipment, and/or financial support (Directive to Take Action); and be it further

RESOLVED, That our AMA recognize the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian COVID-19 pandemic crisis. (Directive to Take Action)

RESOLVED, That our AMA support World Health Organization (WHO) efforts and initiatives to increase production and distribution of therapeutics and vaccines necessary to combat COVID-19 and future pandemics in order to provide vaccine doses to low- and middle-income countries with limited access, including:

1. **A temporary waiver of the Trade Related Aspects of Intellectual Property (TRIPS) agreement and other relevant intellectual property protections;**
2. **Technological transfers relevant for vaccine production;**
3. **Other support, financial and otherwise, necessary to scale up global vaccine manufacturing;**
4. **Measures that ensure the safety and efficacy of products manufactured by such means.**

Resolution 608

RESOLVED, That our American Medical Association call for the cooperation of all governments and international agencies to share data, research and resources for the production and distribution of medicines, vaccines and personal protective equipment (Directive to Take Action); and be it further

RESOLVED, That our AMA promote and support efforts to supply COVID vaccines to health care agencies in other parts of the world to be administered to individuals who can't afford them. (Directive to Take Action)

Resolution 609

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

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

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

Resolution 610

RESOLVED, That our AMA amend policy H-250.988, "Low Cost Drugs to Poor Countries during Times of Pandemic Health Crises," by addition and deletion as follows:

H-250.988 – AID LOW-COST DRUGS TO POOR LOW- AND MIDDLE-INCOME COUNTRIES DURING EPIDEMICS AND PANDEMICS TIMES OF PANDEMIC HEALTH CRISES

Our AMA will: (1) ~~encourages pharmaceutical companies to provide to work with governmental and appropriate regulatory authorities to encourage~~ (a) the prioritization of equity when providing low cost or free medications, including therapeutics and vaccines, to countries; (b) the temporary waiver of intellectual property protections for necessary medications and other countermeasures; and (c) sharing of equipment, materials, scientific methods, and technological information, to facilitate production and distribution of necessary medications during epidemics and pandemics during times of pandemic health crises; and (2) shall work with the World Health Organization (WHO), UNAIDS, and similar organizations that provide comprehensive assistance, including health care, to ~~poor~~ low- and middle-income countries in an effort to improve public health and national stability. (Modify Current HOD Policy)

Resolution 611

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

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

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

Resolutions 608, 609, 610 and 611 call upon the AMA to assist with the humanitarian crisis resulting from the COVID-19 pandemic through sharing supplies with countries that have limited resources. Testimony highlighted the importance of international cooperation to mitigate the spread of COVID-19 and COVID-19 variants as well as to promote herd immunity globally. Speakers offered multiple approaches (e.g., vaccine donations, working with key stakeholders, etc.) to support the production and distribution of vaccines in other counties.

Testimony was heard on other barriers to vaccine production and distribution such as intellectual property rights and emergency use authorization. Due to the complex nature of these issues, your Reference Committee believes that further exploration would be required and could slow the urgent response needed to address the COVID-19 pandemic.

RECOMMENDED FOR NOT ADOPTION

- (6) RESOLUTION 601 – \$100 MEMBER ANNUAL DUES PAYMENT THROUGH 2023

RECOMMENDATION:

Resolution 601 not be adopted.

HOD ACTION: Resolution 601 not be adopted.

RESOLVED, That our American Medical Association adjust dues to \$100 per year for a trial period of two years for actively practicing physicians and senior physicians. (Directive to Take Action)

Your Reference Committee received robust and mixed testimony in response to Resolution 601.

Your Reference Committee gleans from the Whereas clauses contained in the resolution, and from the testimony presented, that the primary intent of the authors is to seek financial relief for physicians who have encountered financial hardships because of COVID-19. Our AMA currently provides a clear path to financial relief with a “financial hardship exemption” for which no financial details are required.

Some testimony suggested the proposed dues adjustment as a method to attract additional members, but your Reference Committee recognizes that membership growth is not the objective of Resolution 601 and, in any event, is not assured as a result of a reduction in dues. Further, your Reference Committee notes that our AMA’s membership efforts throughout the pandemic have produced positive results and it is reported that our AMA is on track to continue the current 10-year growth trend.

Our AMA Board of Trustees testified that a reduction of AMA dues to \$100 would equate to a revenue loss of \$41.8 million over a two-year period. A loss of this magnitude, coupled with the continued economic uncertainty that might cause possible downturns in other funding sources, could move our AMA from maintaining programs and activities to cutting back substantially.

During testimony, our AMA Board of Trustees provided the following perspective. A \$21.9 million reduction in annual dues revenue equates to, at a minimum, over 20% of the funding for strategic focus areas and core activities, including Advocacy, Health & Science, Ethics, Health Equity, Improving Health Outcomes, Accelerating Change in Medical Education and Practice Sustainability and Professional Satisfaction, as well as AMA’s communication and marketing efforts. This is at a time when our AMA is expanding its Center for Health Equity and increasing its focus on public health, all of which require additional funding.

Additional testimony reflected that there could be a negative ripple effect among our Federation members who might be faced with having to justify why similar action is not being implemented at the local or specialty levels. Still further, some projected that it is more likely our AMA would begin losing current membership gains after two

years when the normal dues rates are re-introduced; thus, making a temporary loss in revenue permanent. Lastly, a question was posed with regard to group memberships, which your Reference Committee feels is beyond the scope of this resolution and should be addressed directly by our AMA leadership upon receipt of a formal inquiry.

In closing, your Reference Committee wishes to highlight that our [AMA's membership site](#), as well as a Google search for "AMA financial hardship," will lead members to a financial hardship application. Our AMA Board of Trustees reports that members will be granted a financial hardship exemption if they are a prior year member and submit a financial hardship application. Neither proof nor other supporting documents are required. A request for financial hardship consideration can be renewed annually and is not limited to hardships associated with COVID-19.

RECOMMENDED FOR FILING

- (7) BOARD OF TRUSTEES REPORT 1 - ANNUAL REPORT

RECOMMENDATION:

That Board of Trustees Report 1 be filed.

HOD ACTION: Board of Trustees Report 1 filed.

The Consolidated Financial Statements for the years ended December 31, 2020 and 2019 and the Independent Auditor's report have been included in a separate booklet titled, "2020 Annual Report."

Your Reference Committee received no testimony in direct response to Board of Trustees Report 1. On behalf of our AMA membership, your Reference Committee extends appreciation to the Board of Trustees for executing sound fiscal responsibility despite the unprecedented challenges of this past year due to the pandemic. Additionally, AMA membership increased in 2020 by 6%, marking 10 consecutive years of growth in membership. Emerging from 2020, our AMA continues its ongoing trend of positive operating results and membership engagement.

REPORT OF REFERENCE COMMITTEE G

RECOMMENDED FOR ADOPTION

- (1) BOARD OF TRUSTEES REPORT 9 - PRESERVATION OF THE PATIENT-PHYSICIAN RELATIONSHIP

RECOMMENDATION:

That the recommendation in Board of Trustees Report 9 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 9 adopted and the remainder of the report filed.

The Board of Trustees recommends that Resolution 703-A-19 not be adopted and that the remainder of the report be filed.

A member of the Board of Trustees introduced the report noting that many factors contribute to the patient-physician relationship, including the use of electronic devices and documentation assistance such as scribes. Sometimes these factors result in barriers to optimal communication that interfere with patient care. Barriers created by technology, resource allocation, regulations, and other external factors can detract from the communication and trust between physicians and their patients. These barriers often affect patient health outcomes and/or the physician's ability to provide high-quality care and experience fulfillment and satisfaction in their medical practice. Overcoming the barriers that inhibit effective patient-physician communication is vital to preserving the special and trusted relationship between physicians and their patients. The member stated that the report discusses factors that contribute to patient-physician relationships and when those factors can detract from the physician's ability to provide high quality care or result in barriers to communication that can threaten the patient-physician relationship. The trustee highlighted that our AMA has dedicated significant resources and effort to identifying and addressing the barriers to patient care and effective patient-physician relationships, including the use of technology, documentation requirements, prior authorization, and other work environment factors and that this report also describes those efforts and relevant outcomes.

Testimony on the report was unanimously supportive and thanked the Board of Trustees for its report. Therefore, your Reference Committee recommends that Board of Trustees Report 9 be adopted and the remainder of the report be filed.

- (2) BOARD OF TRUSTEES REPORT 13 - AMENDING THE AMA'S MEDICAL STAFF RIGHTS AND RESPONSIBILITIES

RECOMMENDATION:

That recommendations in Board of Trustees Report 13 be Adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 13 adopted and the remainder of the report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 710-NOV-20 and that the remainder of the report be filed:

That AMA Policy H-225.942, "Physician and Medical Staff Member Bill of Rights," be amended by addition and deletion:

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

Preamble

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

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

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

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

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

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

- a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
- b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.

e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.

f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

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

a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.

b. The responsibility to provide patient care that meets the professional standards established by the medical staff.

c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.

e. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.

g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

h. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.

b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.

c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.

e. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

f. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

g. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

h. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body. (Modify Current HOD Policy)

Your Reference Committee heard positive testimony regarding Board of Trustees Report 13. A member of the Board of Trustees introduced the report, highlighting how the report strengthens current Rights and Responsibilities policy by bolstering protections for physicians who advocate both inside and outside of their organization. The trustee noted that this has been of particular concern in the last year as physicians throughout the country and the world have struggled with access to adequate personal protective equipment and, in some cases, even confronted barriers from their own organizations to obtaining that equipment independently. The report supports the physician's right to advocate without fear of retaliation or retribution. Additionally, the report acknowledges that physicians are entitled to the resources that are necessary to carry out their jobs and provide high-quality patient care. The report achieves these goals by adding modest and reasonable additions to the rights and responsibility articles supporting physicians' right to advocate before their organizations as well as before local, state, and federal decisionmakers while also acknowledging that physicians still bear the responsibility of doing so in ways that support the best interest of patients. Enumerating these rights and responsibilities around physician advocacy strengthens protections for physicians and will help to ensure better working conditions both in times of crisis and during regular operations.

Testimony on the report was supportive, although two delegations offered amendments to the report. The first amendment proposed adding two new subsections to section IV of the Medical Staff Rights and Responsibilities set forth in Board of Trustees Report 13. A trustee testified in opposition to this amendment, explaining that the first proposed new subsection is beyond the scope of the report and that the second proposed new subsection is adequately and more appropriately addressed by current AMA policy. Your Reference Committee notes that section IV of the Medical Staff Rights and Responsibilities as presented in Board of Trustees Report 13, as well as Policies H-215.960, H-385.990, D-383.985, and H-215.968 address the concerns raised by the second proposed new subsection. A second amendment was offered, proposing deletion of the phrase, "right to refuse to work" in section IV (c) of the Medical Staff Rights and Responsibilities set forth in Board of Trustees Report 13. A trustee testified in opposition to this amendment by deletion, emphasizing the ongoing need to protect physicians' right to refuse to work in unsafe conditions. Two delegations testified in support of Board of Trustees Report 13 as presented. Your Reference Committee agrees that Board of Trustees Report 13 should not be amended, and therefore recommends that Board of Trustees Report 13 be adopted and the remainder of the report be filed.

- (3) COUNCIL ON MEDICAL SERVICE REPORT 1 - CMS SUNSET REVIEW OF 2011 HOUSE POLICIES

RECOMMENDATION:

That recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 1 adopted and the remainder of the report filed.

The Council on Medical Service recommends retaining, amending, or rescinding 2011 AMA socioeconomic policies and that the remainder of the report be filed.

Testimony on Council on Medical Service Report 1 was limited to a member of the Council on Medical Service. Accordingly, your Reference Committee recommends that the recommendation of Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

(4) COUNCIL ON MEDICAL SERVICE REPORT 5 - MEDICAL CENTER TRANSFER POLICIES

RECOMMENDATION:

That recommendations in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 5 adopted and the remainder of the report filed.

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

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

H-130.982 Interfacility Patient Transfers of Emergency Patients

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

2. That our AMA amend subsection II(d) of Policy H-225.942 by addition and deletion as follows:

d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, ~~or~~ close medical staff departments, or to transfer patients into, out of, or within the health care organization. (Modify Current HOD Policy)

3. That our AMA amend Policy H-130.965 by addition as follows:

Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association (AHA) and other interested parties to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred. (Modify Current HOD Policy)

4. That our AMA amend Policy H-320.939 by addition of a fourth section as follows:

4. Our AMA advocates for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. (Modify Current HOD Policy)

5. That our AMA reaffirm Policy H-225.957, which provides principles for strengthening the physician-hospital relationship. Policy H-225.957 sets forth parameters for collaboration and dispute resolution between the medical

staff and the hospital governing body, and it establishes that the primary responsibility for the quality of care rendered and for patient safety is vested with the organized medical staff. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-225.971, which details the roles that medical staff and hospital governing bodies and management each and collectively play in quality of care and credentialing. Policy H-225.971 states that hospital administrative personnel performing quality assurance and other quality activities related to patient care should report to and be accountable to the medical staff committee responsible for quality improvement activities. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-285.904, which sets forth principles related to unanticipated out-of-network care. (Reaffirm HOD Policy)

Your Reference Committee heard unanimously positive testimony regarding Council on Medical Service Report 5. A member of the Council on Medical Service introduced and testified in support of the report, explaining that the Council found that current AMA policy lays the groundwork to protect patients and physicians in the context of patient transfers, and this policy can be expanded. The Council member identified the policies the Council recommends amending and reaffirming to optimally protect patients who are transferred among medical facilities and the physicians who care for those patients. Additional testimony on the report was supportive and thanked the Council on Medical Service for its report. Therefore, your Reference Committee recommends that Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

- (5) RESOLUTION 711 - OPPOSITION TO ELIMINATION OF “INCIDENT-TO” BILLING FOR NON-PHYSICIAN PRACTITIONERS

RECOMMENDATION:

That Resolution 711 be adopted.

HOD ACTION: Resolution 711 adopted.

RESOLVED, That our American Medical Association advocate against efforts to eliminate “incident-to” billing for non-physician practitioners among private and public payors. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 711. A member of the Council on Medical Service testified in support of the goals expressed in Resolution 711 but stated that current AMA, including Policy H-160.908, addresses the concerns raised by Resolution 711. Other testimony emphasized the timeliness and importance of Resolution 711 and argued strongly in support of adoption. Your Reference Committee agrees, and as such, recommends that Resolution 711 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (6) COUNCIL ON MEDICAL SERVICE REPORT 3 - UNIVERSAL BASIC INCOME PILOT STUDIES

RECOMMENDATION A:

That Council on Medical Service Report 3 be amended by addition of a new Recommendation to read as follows:

6. That our AMA reaffirm Policy H-290.997 stating that greater equity in the Medicaid program should be achieved through the creation of adequate payment levels to ensure broad access to care. (Reaffirm HOD Policy)

RECOMMENDATION B:

That Council on Medical Service Report 3 be amended by addition of a new Recommendation to read:

7. That our AMA encourage Universal Basic Income pilot studies to measure health outcomes and access to care for patients to increase data on the health effects of these programs. (New HOD Policy)

RECOMMENDATION C:

That Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 3 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 236-A-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-350.974, which states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-290.986, which states that the Medicaid program is a safety net for the nation's most vulnerable populations. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy D-290.979, which directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy D-290.985, which encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services. (Reaffirm HOD Policy)
5. That our AMA actively monitor Universal Basic Income pilot studies that intend to measure participant health outcomes and access to care. (Directive to Take Action)

A member of the Council on Medical Service introduced the report. The Council stated that UBI is one method that is being suggested as having the potential to address income inequality and wage stagnation, and to mitigate the loss of jobs caused by technological advances and COVID-19. The member noted that the concept of UBI is evolving rapidly, particularly in light of the COVID-19 pandemic. The pandemic is catalyzing support for UBI not only in the US but also worldwide. And, since February 2020, governments all over the world, including the US, have distributed cash payments among large portions of their populations to mitigate the loss of jobs and financial disruption of the pandemic. Importantly, the Council noted that, while there have been numerous studies on the effects of UBI, the programs have been population-based and generally have not met minimum standards for randomized control studies. Consequently, there is a void of data on how a sustained UBI program would operate and the far-reaching effects of the program once implemented. Therefore, the Council believes it is best to actively monitor UBI studies as they unfold with a particular eye to studies that intend to measure participant health outcomes and access to care.

Testimony on Council on Medical Service Report 3 was unanimously supportive. One speaker proposed an amendment to add a new recommendation that our AMA encourage universal basic income pilot studies to measure health outcomes and access to care for patients to increase data on the health effects of these programs. Your Reference Committee believes this proposal strengthens the report and recommends this amendment be adopted. Additional testimony called for a new recommendation reaffirming Policy H-290.997, which includes the principle of creating adequate payment levels in the Medicaid program to assure broad access to care. Your Reference

Committee appreciates this suggestion and agrees with reaffirming the policy. Therefore, your Reference Committee recommends that Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

- (7) COUNCIL ON MEDICAL SERVICE REPORT 4 - PROMOTING ACCOUNTABILITY IN PRIOR AUTHORIZATION

RECOMMENDATION A:

That Council on Medical Service Report 4 be amended by addition of a new Recommendation to read as follows:

11. That our AMA advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations. (New HOD Policy)

RECOMMENDATION B:

That Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted as amended by addition of a new Recommendation to read as follows and the remainder of the report filed.

12. That our AMA advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization. (New HOD Policy)

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-320.939 which states that the AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, the Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff; and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policies H-320.948 and H-320.961 which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy H-320.949 which states that utilization management criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policies H-285.998 and H-320.945 which underscore the importance of a clinical basis for health plans' coverage decisions and policies. (Reaffirm HOD Policy)
5. That our AMA reaffirm Policy H-285.939 which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be

- held accountable and liable for medical decisions regarding contractually covered medical services. (Reaffirm HOD Policy)
6. That our AMA advocate that peer-to-peer (P2P) PA determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. (New HOD Policy)
 7. That our AMA advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments. (New HOD Policy)
 8. That our AMA advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable. (New HOD Policy)
 9. That our AMA continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency. (New HOD Policy)
 10. That our AMA rescind Policy D-320.983, which directed the AMA to conduct the study herein. (Rescind HOD Policy)

A member of the Council on Medical Service introduced the report stating that peer-to-peer conversations (P2Ps) usually occur after an initial prior authorization (PA) denial that involves questions of medical necessity or treatment requests that are considered investigational. However, numerous physicians have stated that some insurers are starting to require P2Ps for first-line PAs, and, at times, peer reviewers are unqualified to assess the need for services for an individual patient for whom they have minimal information and with whom they have never evaluated or spoken. Therefore, the Council believes it is critical that reviewing P2P physicians have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments. Additionally, the Council stated that some insurers have suggested that plans should have two business days after the P2P discussion to make a PA decision. The Council disagrees and believes that further delaying the PA determination harms all patients and has a disproportionately negative effect on vulnerable populations. Therefore, the Council recommends requiring that PA decisions be made at the end of the P2P review discussion notwithstanding mitigating circumstances. Finally, the Council noted that it viewed this report through the lens of the COVID-19 pandemic and finds our AMA's efforts to reduce PA burdens especially important during public health emergencies such as the one before us and recommends a reduction in the overall volume of health plans' PA requirements and urges temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency.

Testimony on Council on Medical Service Report 4 was unanimously supportive. One speaker called for an additional recommendation that health plans advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring P2P PA. The Council expressed support for this amendment, and your Reference Committee accepts the recommendation.

Additional testimony called for a new recommendation to advocate that health plans may not require prior authorization on any surgical or other invasive procedure if this procedure is furnished during the course of an operation or procedure that was already approved or did not require prior authorization. In response, a member of the Council on Medical Service stated that this suggestion is already covered in our AMA's PA Principles. Principle 14 states that significant time and resources are devoted to completing PA requirements to ensure that the patient will have the requisite coverage. If utilization review entities choose to use such programs, they need to honor their determinations to avoid misleading and further burdening patients and health care providers. Prior authorization must remain valid and coverage must be guaranteed for a sufficient period of time to allow patients to access the prescribed care. The Principle notes that this is particularly important for medical procedures, which often must be scheduled and approved for coverage significantly in advance of the treatment date. To allow sufficient time for care delivery, a utilization review entity should not revoke, limit, condition or restrict coverage for authorized care provided within 45 business days from the date authorization was received. The Council member also stated that this

surgical and procedural exception is also in our AMA's PA model bill. Your Reference Committee finds the Council's testimony persuasive.

Further testimony requested an amendment that our AMA advocate that all insurance companies and benefit managers that require prior authorization have staff available to timely process and decide on approvals including but not limited to peer review for patients 24 hours a day, every day of the year, including holidays and weekends and within 24 hours. Though your Reference Committee agrees with this sentiment, it notes that Policy D-320.979 and Recommendation 6 of this report satisfy the proposed language. Policy D-320.979 advocates that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends. Moreover, Recommendation 6 advocates that P2P PA determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. Taken together, your Reference Committee finds this suggestion to be a reaffirmation of current policy. Accordingly, your Reference Committee recommends that Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

- (8) COUNCIL ON MEDICAL SERVICE REPORT 6 - URGENT CARE CENTERS

RECOMMENDATION A:

That Recommendation 5 of Council on Medical Service Report 6 be amended by addition and deletion to read as follows:

5. That our AMA supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:

- a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community;**
 - b. UCCs must transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it;**
 - c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;**
 - d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;**
 - e. UCCs should use local physicians as medical directors or supervisors and they should be clearly identified and posted;**
 - f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers; and**
 - g. UCCs should be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or to describe the type of care provided; and**
 - ~~h. UCCs should have 24-hour call coverage to answer patient and subsequent treating physician questions after rendering UCC services.~~**
- (New HOD Policy)

RECOMMENDATION B:

That Recommendation 7 of Council on Medical Service Report 6 be amended by addition and deletion to read as follows:

7. That our AMA support patient education including notifying patients if their physicians are providing extended off-hours care, including weekends, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, ~~and~~ asking for their patients to notify their physician or usual source of care before seeking UCC services, and encourage patients to familiarize themselves with their anticipated out-of-pocket financial responsibility for UCC services. (New HOD Policy)

RECOMMENDATION C:

That Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 6 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-35.985 supporting the physician-led health care team. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-385.926 supporting physicians' choice of practice and method of earning a living. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted to the patient's primary care physician and the administrator of the vaccine should enter the information into an immunization registry, when one exists. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology (CPT) codes, including those for off-hour services. (Reaffirm HOD Policy)
5. That our AMA supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:
 - a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community;
 - b. UCCs must transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it;
 - c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;
 - d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;
 - e. UCCs should use local physicians as medical directors or supervisors;

f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers; and

g. UCCs should be prohibited from using the word “emergency” or “ED” in their name, any of their advertisements, or to describe the type of care provided. (New HOD Policy)

6. That our AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending. (New HOD Policy)

7. That our AMA support patient education including notifying patients if their physicians are providing off-hours care, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, and asking for their patients to notify their physician or usual source of care before seeking UCC services. (New HOD Policy)

A member of the Council on Medical Service introduced the report stating that urgent care centers (UCCs) are proliferating and quickly changing the health care landscape. The rise in the number of UCCs is partially driven by the public’s desire and expectation of prompt, available, and convenient care. While the Council believes that UCCs can serve as a health care access point when a patient’s usual source of care is unavailable, it is acutely aware of the potential of these new clinics to duplicate, fragment, or otherwise undermine patient care. Therefore, in its report, the Council states that it offers a set of principles to which UCCs should adhere to guard against concerns and to ensure that UCCs operate as a modern component of patient-centered care.

Your Reference Committee heard overwhelming supportive testimony for Council on Medical Service Report 6. A speaker suggested an amendment to Recommendation 5(f) to add that medical directors or supervisors should be clearly identified and posted. The Council on Medical Service agreed, and your Reference Committee recommends this amendment be accepted. Additional testimony stated that, after rendering services, UCCs should be available to answer questions or concerns from both patients and physicians 24-hours a day. Your Reference Committee believes this suggestion strengthens the Council’s report and recommends an amendment accordingly.

Further testimony sought to change the mention of off-hours care to extended hours care in Recommendation 7. The Council on Medical Service agreed with the amendment, and your Reference Committee recommends the amendment be accepted. Testimony also stated that patients should familiarize themselves with their anticipated out-of-pocket financial responsibility. To address this concern, the Council on Medical Service proposed an amendment to Recommendation 7, and your Reference Committee recommends acceptance of this amendment. Another speaker requested that this report also be applied to minute clinics. Your Reference Committee does not agree and believes that this suggestion is outside of the scope of this report and highlights that minute clinics have significantly different business models than UCCs. In addition, your Reference Committee notes that AMA policy on retail clinics was established by two previous Council reports.

Therefore, your Reference Committee recommends that Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

- (9) COUNCIL ON MEDICAL SERVICE REPORT 9 - ADDRESSING PAYMENT AND DELIVERY IN RURAL HOSPITALS

RECOMMENDATION A:

That Recommendation 3 in Council on Medical Service Report 9 be amended by addition and deletion to read as follows:

- 3. That our AMA ~~support~~ advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:**
- a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;**
 - b. Provide adequate service-based payments to cover the costs of services delivered in small communities;**
 - c. Adequately compensate ~~Pay for~~ physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner;**
 - d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability;**
 - e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and**
 - f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone. (New HOD Policy)**

RECOMMENDATION B:

That recommendations in Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 9 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-290.979 directing our AMA to support state efforts to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates. (Reaffirm HOD Policy)
3. That our AMA support that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
 - a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume;
 - b. Provide adequate service-based payments to cover the costs of services delivered in small communities;
 - c. Pay for physician standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner;
 - d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability;
 - e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and

- f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone. (New HOD Policy)
4. That our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes. (New HOD Policy)
5. That our AMA support better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital. (New HOD Policy)
6. That our AMA encourage employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians. (New HOD Policy)

A member of the Council on Medical Service introduced the report stating that, despite legislative advances like the Affordable Care Act and Medicaid expansion bringing insurance coverage and health care accessibility to millions of Americans, rural Americans and the health care system intended to serve them continue to face a health care crisis. By most measures, the health of the residents of rural areas is significantly worse than the health of those in urban and suburban areas. On average, rural residents are older, sicker, and are less likely to have health insurance. Concurrently, from 2018 to 2020, 50 rural hospitals closed, accelerating the trend of rural hospital closures. And, of the more than 2,000 rural hospitals across the country, more than 40% of them are estimated to be at risk of closing. Most of these hospitals at risk of closure are small rural hospitals serving isolated rural communities. Long-term solutions are needed to effectively address the health needs of the rural population and protect and enhance their access to health care. Therefore, the Council recommends a set of actions that public and private payers should undertake to ensure payment to rural hospitals is adequate and appropriate.

Your Reference Committee heard testimony unanimously in support of Council on Medical Service Report 9. One speaker asked to amend Policy H-290.976 to advocate that Medicaid payments to providers be at least 101 percent of Medicare payment rates instead of the current policy of at least 100 percent of Medicare. The speaker also suggested an amendment of a new sub-recommendation in Recommendation 3 supporting the expansion of essential services to include Home Health and Hospice thereby advancing equity, given issues of access, large geographic areas, lack of public transportation and lack of internet. The Council on Medical Service replied that our AMA has undertaken significant advocacy efforts on Medicaid payment rates and is unclear what this amendment adds to our AMA's body of policy and how it advances our advocacy agenda. Regarding the second proposed amendment, the Council on Medical Service highlighted that it has two upcoming reports on home health and hospice including a report on home and community-based services and a report on end-of-life payment and hospice. The Council believes that these upcoming reports will satisfy this request. Additionally, Council on Medical Service Report 7 on Addressing Equity in Telehealth that is currently being considered at this meeting and comprehensively addresses concerns around telehealth, broadband, and access. Your Reference Committee finds the Council's testimony persuasive.

An amendment was offered to add a new recommendation calling for appropriate reimbursement to rural hospitals for services offered via telehealth and support increased investment in telemedicine technology at rural facilities. While your Reference Committee appreciates the intent of this amendment, it believes that current AMA policy satisfies this request. Policy D-480.963 advocates for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients. Policy H-478.980 advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States. Policy D-480.969 advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.

Additional testimony called for an amendment to support residency training programs in rural hospitals. While a goal with which the Reference Committee agrees, we believe that amendment is outside the scope of this report. We also highlight Policy H-465.988 calling for our AMA to work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas and to formulate and action plan of advocacy with the goal of increasing residency training in rural areas.

Further testimony called to change Recommendation 3 from “support” to “advocate” and to provide clarifying language to ensure adequate compensation for physician time in Recommendation 3(c). Your Reference Committee agrees with these changes. Testimony also called for deletion of Recommendation 3(f) stating that Recommendation 3(c) accomplishes this goal. Your Reference Committee strongly disagrees and recommends Recommendation 3(f) be adopted.

Accordingly, your Reference Committee recommends that Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

- (10) RESOLUTION 706 - PREVENT MEDICARE ADVANTAGE PLANS FROM LIMITING CARE

RECOMMENDATION A:

That the first Resolve of Resolution 706 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization Medicare guidelines are followed for all both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities, and that care is not limited for patients who chose an Advantage Plan (Directive to Take Action); and be it further

RECOMMENDATION B:

That the second Resolve of Resolution 706 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate ~~that against applying~~ proprietary criteria shall not supersede the professional judgment of the patient’s physician when to determine determining eligibility of Medicare and Medicare Advantage patients eligibility for procedures and admissions when the criteria are at odds with the professional judgment of the patient’s physician. (Directive to Take Action)

RECOMMENDATION C:

That Resolution 706 be adopted as amended.

HOD ACTION: Resolution 706 adopted as amended.

RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services to more tightly regulate Medicare Advantage Plans so that Medicare guidelines are followed for all Medicare patients and care is not limited for patients who chose an Advantage Plan (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that applying proprietary criteria to determine eligibility of Medicare patients for procedures and admissions should not overrule the professional judgment of the patient’s physician. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony on Resolution 706. Amendments were offered to both the first and second Resolve clauses *to clarify that patient care should be driven by physician judgement and evidence-based guidelines and protocols rather than the varying dictates of health plans and insurance companies. The author of the resolution welcomed these amendments. Your Reference Committee agrees with the amendments and proposes an amendment to the first Resolve clause to specifically mention inpatient rehabilitative facility*

admissions. Your Reference Committee believes that patient-centered guidelines for admission to inpatient rehabilitation facilities is the primary goal of the resolution.

One speaker called for referral of Resolution 706. Your Reference Committee does not recognize the merits of referral in light of the substantial support for Resolution 706.

Additional testimony called for an amendment stating that our AMA should ask CMS to add another tool that compares coverage in Medicare Advantage plans vs traditional Medicare and include minimum criteria for coverage/benefits for severe chronic conditions like stroke, cancer or diabetes. Though your Reference Committee agrees with the intent to provide patient education, it notes that our AMA already has significant policy on this issue. Policy D-330.951 directs that our AMA urge CMS to require companies that participate in the MA program to provide enrollees and potential enrollees timely information in a comparable, standardized, and clearly-written format that details enrollment restrictions, as well as all coverage restrictions and beneficiary cost-sharing requirements for all services. Additionally, Policy H-285.913 states that our AMA will pursue legislation to require that MA policies carry a separate distinct page, which the patient must sign, including the statement, “THIS COVERAGE IS NOT TRADITIONAL MEDICARE. [...]” Policy D-330.930 states that our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees. Policy H-330.913 opposes managed care “bait and switch” practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan, but patients who cannot must choose new doctors. Importantly, Policy H-285.902 urges CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website and requiring MA plans to submit accurate provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network.

Accordingly, your Reference Committee recommends that Resolution 706 be adopted as amended.

(11) RESOLUTION 707 – FINANCIAL INCENTIVES FOR PATIENTS TO SWITCH TREATMENTS

RECOMMENDATION A:

That the first Resolve of Resolution 707 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association oppose the practice of insurance companies providing ~~financial incentives~~ payments to for patients as financial incentives to switch treatments from those recommended by their physicians (New HOD Policy); and be it further

RECOMMENDATION B:

That the second Resolve of Resolution 707 be amended by addition to read as follows:

RESOLVED, That our AMA support legislation that would ban insurer policies that provide ~~patients financial incentives~~ payments to patients as financial incentives to switch treatments from those recommended by their physicians, and will oppose legislation that would make these practices legal (Directive to Take Action); and be it further

RECOMMENDATION C:

That the third Resolve of Resolution 707 be amended by addition to read as follows:

RESOLVED, That our AMA engage with state and federal regulators to alert them to identified urging review of the legality of such policies providing financial incentives payments to patients as financial incentives who switch to payer-preferred drugs, and encourage state and federal regulators to prohibit and/or discourage such policies. (Directive to Take Action)

HOD ACTION: Resolution 707 amended by addition and deletion.

RESOLVED, That our American Medical Association oppose the practice of insurance companies providing financial incentives for patients to switch treatments (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation that would ban insurer policies that provide patients financial incentives to switch treatments, and will oppose legislation that would make these practices legal (Directive to Take Action); and be it further

RESOLVED, That our AMA engage with state regulators urging review of the legality of such policies providing financial incentives to patients who switch to preferred drugs. (Directive to Take Action)

Your Reference Committee heard unanimously supportive testimony on Resolution 707, and several amendments were offered. One amendment was offered that would broaden the proposed policy to govern not only financial incentives to change medical treatments but also changes in health care professionals. Members of both the Council on Medical Service and the Council on Legislation opposed this amendment. The Council on Medical Service member explained that in CMS Report 2-I-19, the Council on Medical Service recently studied the increasingly common practice of insurance companies implementing programs that offer patients financial incentives when they compare prices on health care items and services and choose lower-cost options. In CMS Report 2-I-19, the Council found that while such programs can pose risks to patients, they can provide benefits such as reducing care avoidance and cost-related non-adherence to treatment plans. Policy H-185.920 addresses this dynamic in providing principles to guide programs that offer financial incentives to patients who shop for lower-cost health care. Your Reference Committee agrees with the Council on Medical Service's assessment. Several delegations, including the Resolution Sponsors, offered amendments to clarify the text of Resolution 707. The amendment offered by the Resolution Sponsors incorporated amendments from other delegations. The Council on Medical Service supported the Resolution Sponsor's amendment and proposed an additional amendment to provide regulators and AMA Advocacy and with greater flexibility in deterring policies providing financial incentives to patients who switch to payer-preferred drugs. A member of the Council on Legislation testified in support of the Council on Medical Service's amendment. Your Reference Committee notes the consistent intentions expressed by the clarifying amendments, appreciates the compelling testimony provided, and notes that no single amendment incorporated all of the essential clarifying elements. Your Reference Committee has compiled the amendments here and recommends that Resolution 707 be adopted as amended.

RECOMMENDED FOR NOT ADOPTION

- (12) RESOLUTION 702 - ADDRESSING INFLAMMATORY AND UNTRUTHFUL ONLINE RATINGS

RECOMMENDATION:

That Resolution 702 not be adopted.

HOD ACTION: Resolution 702 referred.

RESOLVED, That our American Medical Association take action that would urge online review organizations to create internal mechanisms ensuring due process to physicians before the publication of negative reviews. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 702. A member of the Council on Medical Service testified neither in support nor opposition to Resolution 702 but addressed a comment on the member forum calling for changes to the Health Insurance Portability and Accountability Act (HIPAA) and would like to highlight AMA advocacy activity on this issue. The Council member stated that seeking a change in the HIPAA statute is significant to contemplate and something that our AMA has historically tried to avoid given that the changes may not bode well for physicians. Additionally, in our AMA's most recent attempt to address this issue, it included language in our AMA's HIPAA Notice of Proposed Rulemaking (NPRM) comments from May 2021 asking the Office for Civil Rights (OCR) to develop a process for physicians to respond to online complaints without running afoul of HIPAA's privacy protections. The member noted that patients may not understand how HIPAA permits an organization to share information without the patient's authorization and that covered entities may experience the consequences of such misunderstanding in ways including, but not limited to, complaints to OCR. For example, patients may post complaints on social media about a covered entity for any number of reasons, including misunderstandings around privacy practices. The Council member noted that our AMA receives many complaints from our members who feel that they are unable to respond to such complaints without compromising their confidentiality obligations. Therefore, our AMA continues to encourage OCR to develop a mechanism for physicians to respond to such complaints without violating HIPAA.

A member of the Council on Legislation (COL) underscored the Council on Medical Service's testimony. The COL member stated that it agreed that seeking amendment to the HIPAA statute would be a substantial legislative request requiring considerable AMA expenditure of resources and political capital. And importantly, the Council on Legislation expressed concern that opening HIPAA to such amendments may result in undesirable changes for physicians. Your Reference Committee agrees.

Additionally, your Reference Committee notes that the Code of Medical Ethics addresses physician conduct only. Your Reference Committee does not believe that our AMA can police what individuals post online. Moreover, removing reviews from review sites would likely require an investigation and determination of fact, which the Reference Committee believes is the role of licensing boards. Additionally, your Reference Committee believes that, in extreme circumstances, libel law would be triggered to protect a physician. Taken together, your Reference Committee recommends that Resolution 702 not be adopted.