AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION
(June 2022)

Report of the Medical Student Section Reference Committee

Glen McClain and Rajadhar Reddy, Co-Chairs

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 011 - Expanding Employee Leave to Include Miscarriage and Stillbirth
2. Resolution 017 - Assessing the Humanitarian Impact of Sanctions
3. Resolution 029 - Increasing the Availability of Automated External Defibrillators
4. Delegate Report A – Status of Pending MSS-Authored Resolutions to the House of Delegates
5. COLRP Report A – Region Bylaw Review
6. CSI Report B - Supporting Further Study of Kratom
7. WIM CEQM Report B - National Fertility Coverage Mandate
8. WIM CME Report A - Amendment to Policy H-405.960, Policies for Parental, Family, and Medical Necessity Leave
9. CSI Report C - Support for Creation of Diagnostic Category for Climate-Associated Distress
10. CEQM Report B - Ensuring Competitive Pricing for Pharmaceutical Drugs
11. CAIA Report A - Addressing Longitudinal Health Care Needs of Children in Foster Care
12. WIM Report A - Access to Naloxone for Vulnerable and Underserved Populations
13. WIM CEQM Report A - Amending H-420.978, Access to an Appropriate Reimbursement for Group Prenatal Care
14. CGPH CSI Report A - Mitigating the Impact of Air Pollution on Pediatric Health

RECOMMENDED FOR ADOPTION AS AMENDED

15. Resolution 004 - Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures
16. Resolution 005 - Supporting Intimate Partner and Sexual Violence Safe Leave
17. Resolution 006 - Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Low-Income Families
18. Resolution 008 - Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population
19. Resolution 010 - Inclusion of Disability in Medical Student Mistreatment Reporting
20. Resolution 012 - Revision of H-185.921, Removal of AMA Support for ABA
21. Resolution 014 - Increased Education and Access to Fertility-Related Resources for U.S. Physicians
22. Resolution 015 - Supporting the Use of Gender-Neutral Language
23. Resolution 016 - Amending Policy H-525.988, “Sex and Gender Differences in Medical Research”
24. Resolution 018 - Protecting Access to Abortion and Reproductive Healthcare
25. Resolution 026 - Promoting a Fragrance-Free Health Care Environment

26. Resolution 027 - Recognizing the Burden of Rare Disease
27. Resolution 031 - Indigenous Data Sovereignty
28. Resolution 037 - Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants
29. Resolution 040 - Protecting Workers During Catastrophes
30. Resolution 052 - Promoting Algorithmic Stewardship in Healthcare Systems
31. GC Report A – Review of MSS Sunset Mechanism and Process
32. MIC Report A - Addressing Health Insurance Coverage Disparity among Latinx Children
33. CSI CGPH Report A - Addressing Inequity in Onsite Wastewater Treatment
34. CAIA Report B - Amending Policy on Public Option to Maximize AMA Advocacy
35. CSI Report A - Advocating for Plant-Based Meat Research and Regulation
36. COLA CGPH Report A - Reducing Burden of Incarceration on Public Health
37. CEQM Report A - Studying Population-Based Insurance and Payment Policy Disparities
38. CGPH CBH Report A - Opposing Use of Vulnerable Incarcerated People in Response to Public Health Emergencies of Infectious Disease Origin
39. CDA CME Report A - Expanding Support for Medical Students and Physicians with Disabilities

RECOMMENDED FOR ADOPTION IN LIEU OF

40. Resolution 001 - Opposing the Censorship of Sexuality and Gender Identity Discussions in Public Schools
41. Resolution 003 - Accessible Electronic Charting Software and Alternative Access to Health Information for Visually Impaired Patients
42. Resolution 007 - Interrupted Patient Sleep
43. Resolution 009 - Addressing the Use of Mail-order Naloxone to Curb the Opioid Epidemic
44. Resolution 013 - Dismantling Homelessness Brick by Brick - An Eviction & Rate-Centered Action to Prevent Homelessness
45. Resolution 020 - Adoption of Accessible Medical Diagnostic Equipment Standards
46. Resolution 022 - Accuracy and Awareness for Sex Representation in Medical Textbooks
47. Resolution 024 - Reforming the FDA Accelerated Approval Process
48. Resolution 030 - SNAP Expansion for DACA Recipients
49. Resolution 033 - Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use
50. Resolution 035 - FDA Indications for Off-Label & Over-the-Counter Drugs
51. Resolution 055 - Incorporating Holocaust Education in Medical Schools on International Remembrance Day
52. IOP/ETF Report - Internal Operating Procedures/Election Task Force Report
53. COLRP COLA Report A – Promotion and Support of Physician, Student, and Patient Participation in Government

Resolution 002 – Supporting Voting for Hospitalized Patients

RECOMMENDED FOR REFERRAL

54. Resolution 021 - Expanding and Reclassifying Emergency Medical Services

55. Resolution 036 - Fortifying Fat-Soluble Foods with Vitamin D
56. Resolution 042 - Condemnation of Non-Therapeutic Sterilization for Contraception of Women with Disabilities without Informed Patient Consent
57. Resolution 049 - Advocating for the Inclusion of Weight Bias Training for Medical Students
58. GC Report B – Resolution Task Force 2022 Update
59. MIC CGPH Report A - Mental Health Reform in Prisons

RECOMMENDED FOR NOT ADOPTION

60. Resolution 019 - Improving Safety of Planned Home Births through Midwifery Licensing and Regulation
61. Resolution 025 - Medical Histories of Gamete Donors and Donor Conceived People
62. Resolution 032 - Support for Mandated Nurse-Patient Ratios
63. Resolution 034 - Pharmacy Access to Human Immunodeficiency Virus (HIV) Pre-Exposure Prophylaxis (PrEP) & Post-Exposure Prophylaxis (PEP)
64. Resolution 038 - Supporting Research into Artificial Womb Technologies
65. Resolution 043 - The Impacts of COVID-19 and Telemedicine on National Opioid Prescription Patterns
66. Resolution 054 - Decreasing Screen Time in School and for School-related Activities
67. COLA MIC Report A - IMG Exemptions from Immigration Caps on IMG-Specific Immigration Category for Green Cards and Visas

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

68. Resolution 023 - Incorporation of Evidence-Based Vaccine Communication Strategies in Medical School Curriculum
69. Resolution 028 - Treatment Programs for Adolescents with Substance Use Disorder
70. Resolution 039 - Medical Reversal
71. Resolution 041 - Encouraging Increased Dermatologic Training in Primary Care Settings to Reduce Racial Disparities in Melanoma Outcomes
72. Resolution 044 - Increased Doula Access to Support Pregnant and Birthing People
73. Resolution 045 - Reforming The Residency Match System
74. Resolution 046 - Subsidizing Research into Molecular Nanotechnology and Molecular Nanomachines in Medicine
75. Resolution 047 - Subsidizing Research into Bacteriophage Medicine
76. Resolution 048 - Ensure Fair Practices by Staffing Agencies
77. Resolution 050 - Accurately Quantifying E-cigarette Usage
78. Resolution 051 - Expanding Access to Telerehabilitation
79. Resolution 053 - Repurposing Medical Surplus for Humanitarian Relief and Medical Education
80. Resolution 056 - Regulation of Data from Mobile Health Technology
81. Resolution 057 - Supporting the Research and Development of the “Perfect Potato”

RECOMMENDED FOR FILING

82. LGBTQ+ Report A – A Report on the Status of Requests Relating to LGBTQ+ Affairs Made by the AMA-MSS to the AMA

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 011 - EXPANDING EMPLOYEE LEAVE TO INCLUDE MISCARRIAGE AND STILLBIRTH

RECOMMENDATION:

Resolution 011 be adopted.

RESOLVED, That our AMA amends Policy H-405.960, “Policies for Parental, Family, and Medical Necessity Leave”:

Policies for Parental, Family and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.

2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption; and (j) leave policy for miscarriage or stillbirth.

3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after miscarriage or stillbirth ; ~~(c)~~(d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); ~~(d)~~(e) whether leave is paid or unpaid; ~~(e)~~(f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; ~~(f)~~(g) whether sick leave and vacation time may be accrued from year to year or used in advance; ~~(g)~~(h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; ~~(h)~~(i) how time can be made up in order for a resident physician to be considered board eligible; ~~(i)~~(j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; ~~(j)~~(k) whether time spent in making up a leave will be paid; and ~~(k)~~(l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth, stillbirth, miscarriage, and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.
and be it further

RESOLVED, that due to the prevalence of miscarriage and stillbirth and the need for physical and psychological healing afterwards, our AMA amends H-420.979 “AMA Statement on Family and Medical Leave” as follows:

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy~~;~~, miscarriage, and stillbirth;
(2) maternity leave for the employee-mother;
(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

VRC testimony was entirely supportive of the resolution. The Reference Committee agrees with VRC testimony that the resolution succinctly addresses an important gap in policy. While we of course realize that both this resolution and Resolution 005 on safe leave amend the same policy, we refrained from combining these resolutions to avoid conflating these two distinct and highly important issues. We recognize that the proposed amendments do not conflict with each other, so if these resolutions were to be adopted in the House of Delegates, they could both be cleanly amended into existing policy simultaneously. We recommend Resolution 011 be adopted.

(2) RESOLUTION 017 – ASSESSING THE HUMANITARIAN IMPACT OF SANCTIONS

RECOMMENDATION:

Resolution 017 be <u>adopted</u>.

RESOLVED, That our AMA recognizes that economic sanctions can negatively impact health and exacerbate humanitarian crises; and be it further

RESOLVED, That our AMA supports legislative and regulatory efforts to study the humanitarian impact of economic sanctions imposed by the United States.

VRC testimony was nearly universally supportive of the resolution with testimony from the MSS Minority Issues Committee (MIC), the MSS representative to the Minority Affairs Section (MAS), Region 1, Region 2, Region 3, and Region 6, with only one individual in opposition. The Reference Committee agrees with testimony that the resolution addresses a gap in policy and the asks are within the AMA’s scope. We found the resolution to be well-researched and were compelled by the authors’ testimony that global and humanitarian health issues–and how they are affected by federal policy–are within our purview for advocacy, as noted by their discussion of the AMA’s statement on

the war in Ukraine. We also recognize their testimony explaining that this resolution does not ask our AMA to oppose the use of sanctions or presume to make those foreign policy decisions for Congress and the White House, but simply asks for recognition of their well-evidenced potential health consequences and for support of efforts to understand their impact and inform future global decisions. We note that the authors' second resolve clause on legislative and regulatory study mirrors existing Congressional legislation. We recommend Resolution 017 be adopted.

(3) RESOLUTION 029 - INCREASING THE AVAILABILITY OF AUTOMATED EXTERNAL DEFIBRILLATORS

RECOMMENDATION:

Resolution 029 be <u>adopted</u>.

RESOLVED, That our AMA amend Policy H-130.938, "Cardiopulmonary Resuscitation (CPR) and Defibrillators,**"** by addition to read as follows:

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:
(1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
(2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
(3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
(4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
(5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
(6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
(7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
(8) supports the development and use of universal connectivity for all defibrillators;
(9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
(10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
(11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
(12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.

(13) encourages the distribution of Automated External Defibrillators in an equitable manner through the utilization of targeted placement strategies in order to increase availability and decrease disparities in areas where disproportionate rates of out-of-hospital cardiac arrest episodes exist.

VRC testimony was supportive but limited. The Reference Committee agrees with testimony that supports equitable distribution of Automated External Defibrillators (AEDs). While we recognize that implementation of this policy may be difficult, we also believe that this should not hinder us from supporting logically sound efforts to allocate public health resources such as AEDs. We were compelled by the resolution's argument that existing community AED placement, a widespread investment purportedly made to improve rapid care for cardiac arrest, may be inadequate to address the numbers and locations of cardiac arrests that occur, particularly in communities geographically deprioritized by public health departments due to systemic racism and poverty. The resolution presents reasonable evidence for this argument, especially given that such data may be limited in part because of well-documented and well-understood inequities widely accepted by our MSS and in line with our values. We recommend Resolution 029 be adopted.

(4) DELEGATE REPORT A – STATUS OF PENDING MSS-AUTHORED RESOLUTIONS TO THE HOUSE OF DELEGATES

RECOMMENDATION:

The Recommendations in Delegate Report A be adopted and the remainder of the report be filed.

Your Section Delegates recommend that the following resolutions be discharged from the transmittal queue:

1. Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System
2. Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises [only discharging the second Resolved clause]
3. Improving Support and Access for Medical Students with Disabilities
4. Patient Education and Security Risks Involving DTC Genetic Testing
5. Reducing Complexity in the Public Service Loan Forgiveness
6. Support for Vote-by-Mail
7. Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants

Your Section Delegates further recommend that the following resolutions be combined:

1. Ending Tax Subsidies for Advertisements Promoting Food and Drink of Poor Nutritional Quality Among Children/Amend H-150.927, to Include Food Products with Added Sugar (new title: Increasing Awareness and Reducing Consumption of Food and Drink of Poor Nutritional Quality)
2. Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises/Using X-Ray and Dental Records for Assessing Immigrant Age (new title: Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities)

3. Addressing Need for Firearm Safety in Medical School Curricula/Amend H-145.976, to Reimburse Physicians for Firearm Counseling (new title: Training and Reimbursement for Firearm Safety Counseling)
4. Support Removal of BMI as a Standard Measure in Medicine/Increased Recognition and Treatment of Eating Disorders in Minority Populations (new title: Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders)
5. Protections for Incarcerated Mothers in the Perinatal Period/Opposition to Immediate Separation of Infants from Incarcerated Pregnant Persons (new title: Protections for Incarcerated Mothers and Infants in the Perinatal Period)
6. Online Medical School Interview Option/Supporting a Hybrid Residency and Fellowship Interview Process (new title: Studying Virtual and Hybrid Options for Medical School, Residency, and Fellowship Interviews)

Your Section Delegates further recommend that the titles of the following resolutions be updated as follows:

1. Government Manufacturing of Generic Drugs to Address Market Failures (formerly Pharmaceutical Drug Pricing: Parameters around Medicare Negotiation and Government Manufacturing of Generic Drugs)
2. Amending H-90.968 to Expand Policy on Medical Care of Persons with Disabilities (formerly: H-90.968, Medical Care of Persons with Developmental Disabilities Amendment)
3. Support of Vision Screenings and Visual Aids for Adults Covered by Medicaid (formerly: Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid)
4. Advocating for the Elimination of Hepatitis C Treatment Restrictions (formerly: Opposition to Sobriety Requirement for Hepatitis C Treatment)

Your Section Delegates further recommend that the following resolutions be held in the queue for the duration of the current meeting being due to other ongoing movement on related items:

1. Addressing Longitudinal Health Care Needs of Children in Foster Care
2. Amending H-160.903, Eradicating Homelessness to Include Support for Street Medicine Programs
3. Encouraging Collaboration between Physicians and Industry in AI Development
4. Establishing Comprehensive Dental Benefits Under State Medicaid Programs
5. Gender Neutral Language in AMA Policy
6. Reducing Disparities in HIV Incidence through PREP for HIV
7. Support of Research on Vision Screenings and Visual Aids for Adults Covered by Medicaid

Your Section Delegates further recommend updating the Resolved clauses in the following resolution to spell out the acronyms used therein:

1. Amending Policy H-155.955, Increasing Accessibility to Incontinence Products to Include Diaper Tax Exemptions

There was no VRC testimony on Delegate Report A. The Reference Committee recognizes the MSS Section Delegates for their work on the transmittal process. We recognize that the transmittal process has evolved in various ways over the last few cycles to best rapidly adapt to the changing nature of the House of Delegates Resolutions

Committee. With the hopeful return of in-person HOD meetings allowing our MSS Caucus to more efficiently transmit the remainder of our backlog, we would encourage future transmittal processes to involve reviewing resolved clauses to ensure topical alignment before combining resolutions, consulting with the original authors prior to combining items or changing titles to clarify whether such decisions logically flow or present the individual issues in the best light, hosting transmittal meetings that are open to and visibly advertised to all MSS members (especially original resolution and report authors), including a formalized comment period for input by all MSS members (again, especially authors) on transmittal decisions, and making an easily accessible and readable list of all confirmed transmittals for the upcoming meeting available to all MSS members (beyond the table included in this report describing all items in queue). Your Reference Committee recommends that the recommendations in Delegate Report A be adopted and the remainder of the report be filed.

(5) COLRP REPORT A – REGION BYLAW REVIEW

RECOMMENDATION:

The Recommendations of COLRP Report A be <u>adopted</u> and the remainder of the report be <u>filed</u>.

In alignment with MSS policy 665.012MSS, your COLRP recommends the following:

1. That our MSS Speaker and Vice Speaker monitor all MSS Regions to ensure compliance with the minimum requirements in GC Report D, A-15; and
2. That Region 6 modify their bylaws to specify the responsibilities of the Region Chair to be in accordance with MSS IOP 8.1.3; and
3. That Region 7 modify their bylaws to describe the Region Chair responsibilities and the selection of Region Delegation Chair to be in accordance with MSS IOP 8.1.3 and MSS IOP 8.3; and
4. That our MSS-COLRP reevaluate the accordance of each Region's bylaws with the categories in Tables 1 – 5b and release its findings in an informational report to the Assembly at A-24; and
5. The remainder of this report be filed.

VRC testimony was supportive of COLRP Report A. We agree with testimony noting that COLRP found some important discrepancies that should be addressed and suggesting that the recommendations are reasonable. Your Reference Committee recommends that the recommendations in COLRP Report A be adopted and the remainder of the report be filed.

(6) CSI REPORT B – SUPPORTING FURTHER STUDY OF KRATOM

RECOMMENDATION:

The Recommendations of CSI Report B be <u>adopted</u> and the remainder of the report be <u>filed</u>.

Kratom and its Growing Use Within the United States H-95.934

Our AMA: supports ~~legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research.~~ efforts to further study the clinical uses, benefits, and potential harms of Kratom, and opposes efforts that may restrict research.

VRC testimony was limited but all supportive of CSI Report B. Your Reference Committee commends CSI on this well-written report and agrees with CSI's amendments to remove our support for Kratom prohibition while strengthening our stance on Kratom research. While your Reference Committee considered whether the proposed CSI language should include mention of possible bans or criminalization of Kratom, we remembered that we have a pending MSS transmittal on overall decriminalization of drugs that would achieve that ask broadly, while keeping this ask specific to the clinical and scientific questions surrounding Kratom. The Reference Committee recommends the recommendations of this report be adopted and the remainder of the report be filed.

(7) WIM CEQM REPORT B - NATIONAL FERTILITY COVERAGE MANDATE

RECOMMENDATION:

The Recommendation of WIM CEQM Report B be adopted and the remainder of the report be filed.

Your Women in Medicine Standing Committee and Committee on Economics & Quality in Medicine recommends that the following be adopted and the remainder of this report be filed:

RESOLVED, That our AMA amend Policy H-185.990, "Infertility and Fertility Preservation Insurance Coverage" by addition and deletion to read as follows:

1. Our AMA ~~encourages third party payer health insurance carriers to make available insurance benefits~~ supports federal protections that ensure insurance coverage by all payers for the diagnosis and treatment of recognized ~~male and female~~ infertility.

2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

3. Our AMA will study feasibility of insurance coverage for fertility preservation for reasons other than iatrogenic infertility.

VRC testimony was limited but supportive. Your Reference Committee agrees with testimony that the recommendations of this report would increase access to fertility benefits for all who seek these services and appreciate the removal of the reference to binary sex. We thank WIM for a well-written report that simplifies the ask of the original resolution referred to them, retaining the strength of our original stances on infertility and

iatrogenic infertility specifically without altering this language unnecessarily or inadvertently removing existing policy. We agree that the addition of another clause is the most effective way to address coverage of general fertility preservation and also agree that an external AMA study is appropriate for this issue, especially given the controversial exclusion of many types of health services believed to be “optional” from both public and private plans. We recommend the recommendations in the report be adopted and the remainder of the report be filed.

(8) WIM CME REPORT A - AMENDMENT TO POLICY H-405.960, POLICIES FOR PARENTAL, FAMILY, AND MEDICAL NECESSITY LEAVE

RECOMMENDATION:

The Recommendation of WIM CME Report A be <u>adopted</u> and the remainder of the report be <u>filed</u>.

Your Committees on Women in Medicine (WIM) and Medical Education (CME) recommend that the following recommendation be adopted as amended and that the remainder of this report be filed:

Policies for Parental, Family and Medical Necessity Leave, H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges ~~medical schools,~~ residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for ~~medical students and~~ physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.

3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation without delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
~~8.~~ 9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

~~9.~~ 10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
~~10.~~ 11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
~~11.~~ 12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
~~12.~~ 13. Our AMA encourages flexibility in residency training programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees~~house staff~~.
~~13.~~ 14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
~~14.~~ 15. These policies as above should be freely available online and in writing to all current trainees and applicants to medical school, residency or fellowship.

VRC testimony was supportive. The Reference Committee agrees with testimony that the recommendations address a gap in existing policy by expanding parental leave to medical students. We thank WIM and CME for a well-written report and resolve language that neatly and effectively creates a separate clause for leave conditions specific to medical students, mirroring the preceding clause on residents, while allowing reasonable flexibility for individual medical schools and variable curricula timelines. We recommend the recommendation of this report be adopted and the remainder of the report be filed.

(9) CSI REPORT C - SUPPORT FOR CREATION OF DIAGNOSTIC CATEGORY FOR CLIMATE-ASSOCIATED DISTRESS

RECOMMENDATION:

The Recommendation of CSI Report C be adopted and the remainder of the report be filed.

Your Committee on Scientific Issues recommends that Resolution 061 not be adopted, and the remainder of this report be filed.

VRC testimony was limited and supportive of the report recommendation. The Reference Committee agrees with testimony in support of the report's recommendation to not adopt the antecedent resolution because the AMA opposes the International Classification of Diseases (ICD) classification system and the report did not find evidence for direct causation of pathological mental distress from climate change. Lastly,

climate-associated distress is not a diagnosis listed in the DSM V, and the reference committee agrees that a resolution like should be put forward by or in partnership with the APA. While we remember that the November 2021 MSS Reference Committee recommended adopting the antecedent resolution with major amendments to clarify its intent, we recognize CSI's consideration of this proposal as well and appreciate their discussion. Thus, we recommend the recommendations of CSI Report C be adopted and the remainder of the report be filed.

(10) CEQM REPORT B - ENSURING COMPETITIVE PRICING FOR PHARMACEUTICAL DRUGS

RECOMMENDATION:

The Recommendation of CEQM Report B be <u>adopted</u> and the remainder of the report be <u>filed</u>.

Your Committee on Economics and Quality in Medicine recommends that the Resolution 057 not be adopted, and the remainder of this report be filed.

VRC testimony was limited but supportive. We thank CEQM for an excellent and comprehensive report on a very complex issue. The Reference Committee agrees with testimony pointing out concerns that Quality of Added Life Years (QALY) thresholds could introduce, including for patients with disabilities and chronic illnesses. We also appreciate the report's discussion of alternatives mentioned in the antecedent resolution, such as the equal value of life-years gained (evLYG) measure. We agree with CEQM's ultimate conclusion that due to the uncertainty over these measures, we should refrain from support of these measures. We also recognize that existing AMA policy already broadly supports value-based pricing for pharmaceuticals and that explicit endorsement of specific cost effectiveness measures may be unnecessary. We recommend that the recommendation of CEQM Report B be adopted, and the remainder of this report be filed.

(11) CAIA REPORT A - ADDRESSING LONGITUDINAL HEALTH CARE NEEDS OF CHILDREN IN FOSTER CARE

RECOMMENDATION:

The Recommendations of CAIA Report A be <u>adopted</u> and the remainder of the report be <u>filed</u>.

Your Committee on American Indian Affairs recommends that the following recommendations be adopted, and the remainder of this report is filed:

1. The AMA supports federal legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause.
2. The AMA will work with local and state medical societies and other relevant stakeholders to support legislation preventing the removal of American Indian and Alaska Native children from their homes by public and private agencies without cause.

3. The AMA supports state and federal funding opportunities for American Indian and Alaska Native child welfare systems.
4. Our AMA-MSS will immediately forward this report to the A-22 meeting of the AMA House of Delegates.

VRC testimony was supportive of the report recommendations. The Reference Committee agrees with testimony that the immediate forward clause is important because arguments about the Indian Child Welfare Act (ICWA) will soon be heard by the United States Supreme Court. We also commend our new MSS Committee on American Indian Affairs (CAIA) on their establishment and their thoughtful analysis on protection of AI/AN children's rights. We thank the authors for a well-written report and recommend the recommendations of the report be adopted and the remainder of the report be filed.

(12) WIM REPORT A - ACCESS TO NALOXONE FOR VULNERABLE AND UNDERSERVED POPULATIONS

RECOMMENDATION:

The Recommendation of WIM Report A be <u>adopted</u> and the remainder of the report be <u>filed</u>.

Your AMA-MSS Women in Medicine Standing Committee recommends that the following be adopted and the remainder of this report be filed:

RESOLVED, That our AMA amend Policy H-420.950, "Substance Use Disorders During Pregnancy" by addition and deletion to read as follows:

> Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected, <u>and (5) that our AMA support universal opioid use screenings at prenatal care visits with early intervention, comprehensive naloxone use education and distribution for those who screen positive and following overdose-related emergency department visits.</u>

VRC testimony was supportive. The Reference Committee agrees with testimony that the report is well written. We recognize that the proposed addition is robustly supported by clinical guidelines from the American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP), American Society of Addiction Medicine (ASAM), and American Academy of Addiction Psychiatry (AAAP). We

recommend the report recommendation be adopted and the remainder of the report be filed.

(13) WIM CEQM REPORT A - AMENDING H-420.978, ACCESS TO AN APPROPRIATE REIMBURSEMENT FOR GROUP PRENATAL CARE

RECOMMENDATION:

The Recommendation of WIM CEQM Report A be adopted and the remainder of the report be filed.

Our Women in Medicine (WIM) Committee and Committee on Economics and Quality in Medicine (CEQM) recommend that the Resolution 038 not be adopted, and the remainder of the report is filed.

VRC testimony on WIM CEQM Report A was limited. We recognize that WIM and CEQM have written multiple drafts of this report and thank them for their excellent and comprehensive effort. The Reference Committee agrees with testimony that the antecedent resolution appears to be covered by existing policy. H-160.911, "Value of Group Medical Appointments," which states "Our AMA promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy." We also agree with the authors that the variability of group prenatal care programs and their implementation in specific settings makes the creation of model legislation by our AMA difficult. We also appreciate their extensive discussion of the health equity considerations with group prenatal care. We believe that the authors' analysis and existing AMA policy align with The American College of Obstetricians and Gynecologists' (ACOG) 2018 Committee Opinion (reaffirmed in 2021) on group prenatal care cited in the report, which says that "individual and group care models warrant additional study with a goal of demonstrating differences in outcomes and identifying populations that benefit most from specific care models." Future MSS members interested in group prenatal care specifically may consider working directly with ACOG on this issue. Thus, we recommend that the recommendations of this report be adopted, and the remainder of the report filed.

(14) CGPH CSI REPORT A - MITIGATING THE IMPACT OF AIR POLLUTION ON PEDIATRIC HEALTH

RECOMMENDATION:

The Recommendation of CGPH CSI Report A be adopted and the remainder of the report be filed.

Your Committee on Scientific Issues and Committee on Global and Public Health recommend that the Resolution 029 not be adopted, and the remainder of this report is filed.

VRC testimony was limited. Your Reference Committee agrees with testimony that the asks of Resolution 029 are supported by the AMA through its specific policy on the reduction of diesel emissions, D-135.996, which can be sufficient justification of support

for the federal regulatory standards taking place in 2027, including the EPA's proposed "Control of Air Pollution From New Motor Vehicles: Heavy-Duty Engine and Vehicle Standard" which includes transitioning away from diesel buses. Therefore, we recommend the recommendations of this report be adopted and the remainder of the report filed.

D-135.996 Reducing Sources of Diesel Exhaust
Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPA's proposal to roll back the "glider Kit Rule" which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards.

RECOMMENDED FOR ADOPTION AS AMENDED

(15) RESOLUTION 004 - PAIN MANAGEMENT FOR LONG-ACTING REVERSIBLE CONTRACEPTION AND OTHER GYNECOLOGICAL PROCEDURES

RECOMMENDATION A:

The first Resolve of Resolution 004 be amended by deletion:

~~**RESOLVED, That our AMA encourages the availability of training for physicians to incorporate information on the use of local pain control techniques for gynecological procedures; and be it further**~~

RECOMMENDATION B:

The second Resolve of Resolution 004 be amended by addition to read as follows:

RESOLVED, That our AMA recognizes the disproportionate impacts of pain in gynecological procedures and encourages discussion of pain control options, risks, and benefits with patients as a part of the shared decision-making process ~~for gynecological procedures as a part of the informed consent discussion~~; and be it further

RECOMMENDATION C:

Resolution 004 be adopted as amended.

RESOLVED, That our AMA encourages the availability of training for physicians to incorporate information on the use of local pain control techniques for gynecological procedures; and be it further

RESOLVED, That our AMA encourages discussion of pain control options, risks, and benefits with patients as a part of the shared decision-making process for gynecological procedures as a part of the informed consent discussion; and be it further

RESOLVED, That our AMA supports further research into evidence-based anesthetic and anxiolytic medication options for long-acting reversible contraception procedures and other gynecological procedures, including but not limited to colposcopy, endometrial biopsy, and LEEP procedures.

VRC testimony was mixed. Your Reference Committee recommends that the first resolved clause be deleted due to such physician training being more appropriately the purview of American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), and other societies that specialize in gynecological procedures and can appropriately address any clinical guidelines. While we recognize the authors' argument that AMA policy on neonatal male circumcision includes language on training programs for local pain control, we also note that this policy is from 1999. The more contemporary H-185.931, which is not cited in the resolution, states that "Our AMA

supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted," and this policy seems more appropriately related for the authors' asks. The authors may consider working directly with ACOG, AAFP, and other societies to achieve this ask. Additionally, we simplified the second resolve to emphasize the shared decision-making process, which would presumably include informed consent, and added language that captures the intent of the resolution, noting that inadequate pain management for these procedures is a problem. Lastly, we agree with testimony that the third resolved clause on research is novel and well written. The Reference Committee recommends this resolution be adopted as amended to address concerns outlined above.

(16) RESOLUTION 005 – SUPPORTING INTIMATE PARTNER AND SEXUAL VIOLENCE SAFE LEAVE

RECOMMENDATION A:

The first Resolve of Resolution 005 be <u>amended by deletion</u> to read as follows:

RESOLVED, That our AMA recognize the positive impact of paid safe leave on public health outcomes and support legislation that offers ~~paid and unpaid~~ safe leave; and be it further

RECOMMENDATION B:

Resolution 005 be <u>adopted as amended.</u>

RESOLVED, That our AMA recognize the positive impact of paid safe leave on public health outcomes and support legislation that offers paid and unpaid safe leave; and be it further

RESOLVED, That our AMA amend the existing policy H-420.979 AMA Statement on Family and Medical Leave to promote inclusivity by addition as follows:

> AMA Statement on Family and Medical Leave, H-420.979
> Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions <u>and/or concerns for safety</u>. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; (4) leave for adoption or for foster care leading to adoption<u>; and (5) safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking</u>. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking

into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

VRC testimony was overall supportive of the resolution. The Reference Committee agrees with VRC testimony that encourages the clarification of safe leave through amendments. We believe the general term “safe leave” covers both paid and unpaid leave as supported by the whereas clauses. We amended the first resolve to emphasize paid safe leave, given the whereas clauses, to aspire for legislation on paid safe leave without removing the possibility of supporting even the far less preferable option of unpaid safe leave. We retained “paid or unpaid” in the second resolve’s amendment to existing policy, just as the authors did, to remain agnostic on this point, especially since that policy also discusses many other types of leave. Finally, while we of course realize that both this resolution and Resolution 011, which discusses leave for stillbirth and miscarriage, amend the same policy, we refrained from combining these resolutions to avoid conflating these two distinct and highly important issues. We recognize that the proposed amendments do not conflict with each other, so if these resolutions were to be adopted in the House of Delegates, they could both be cleanly amended into existing policy simultaneously. Thus, your Reference Committee recommends Resolution 005 be adopted as amended.

(17) RESOLUTION 006 - RECOGNIZING CHILD POVERTY AND THE RACIAL WEALTH GAP AS PUBLIC HEALTH ISSUES AND EXTENDING THE CHILD TAX CREDIT FOR LOW-INCOME FAMILIES

RECOMMENDATION A:

Policy H-65.952 be <u>reaffirmed in lieu of</u> the second Resolve of Resolution 006.

RECOMMENDATION B:

The third Resolve of Resolution 006 be <u>amended by deletion</u> as follows:

RESOLVED, That our AMA advocate for ~~monthly, fully refundable, and~~ expanded child tax credit payments and other evidence-based cash assistance programs to alleviate child poverty, ameliorate the racial wealth gap, and advance health equity for low-income U.S. residents; and be it further

RECOMMENDATION C:

Resolution 006 be <u>adopted as amended</u>.

RESOLVED, That our AMA recognize child poverty as a public health issue and a crucial social determinant of health across the life course; and be it further

RESOLVED, That our AMA recognize that the disproportionate concentration of child poverty and generational wealth gaps experienced by Black, Indigenous, and Hispanic families are a consequence of structural racism and a barrier to achieving racial health equity; and be it further

RESOLVED, That our AMA advocate for monthly, fully refundable, and expanded child tax credit payments and other evidence-based cash assistance programs to alleviate child poverty, ameliorate the racial wealth gap, and advance health equity for low-income U.S. residents; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the A-22 AMA House of Delegates.

VRC testimony was supportive of the first resolved clause as written and your Reference Committee concurs. The second resolved clause was placed on the reaffirmation consent calendar by the House Coordination Committee (HCC). Your Reference Committee recognizes the authorship team's extensive testimony against reaffirmation of this clause. However, while this cycle HCC graciously granted us the ability to remove a resolve from the reaffirmation consent calendar if we amended it to make it novel, we could not devise a way to effectively amend the second resolve to address HCC's concerns and ultimately agreed with their reaffirmation of H-65.952 in lieu of the clause. The third resolve clause had mixed testimony on the VRC. The authorship team offered a response to various amendments on the third resolve clause, and we found their rationale to keep the race-specific language compelling. We also believe that our retention of this language effectively includes the key points from the reaffirmed second resolve. We made additional amendments to the third resolve to avoid prescriptiveness and possible technical questions in the House of Delegates that distract from the key issue here. We understand the arguments made in the resolution for the benefits of monthly and fully refundable payments. We recognize that Congress' American Rescue Plan of 2021 (ARP) included both these provisions and that the proposed but unpassed Build Back Better Act of 2021 (BBB) would have made the fully refundable expanded payments permanent and would have extended monthly payments through 2022, as the implementation of monthly payments was in part due to the timeline of passage of each bill before tax season. However, since the BBB did not necessarily make monthly payments permanent, and given the politically difficult nature of that bill in the Senate, we believe that "expanded" is appropriately inclusive of the various efforts proposed by the ARP and BBB and allows our AMA to flexibly advocate for the most likely passage of increased payments. Your Reference Committee agrees with VRC and supports the immediate forwarding clause due to the ongoing national debate surrounding child tax credits. We also recognize that the Michigan delegation has transmitted a similar resolution on the expanded child tax credit to the 2022 Annual Meeting of the House of Delegates as well. While the asks are aligned and overlap, we believe that transmitting our resolution alongside theirs will increase awareness of this issue and allow the best language of both resolutions, such as our resolution's mention of child poverty and the racial wealth gap, to be combined effectively. We recommend Resolution 006 be adopted as amended.

H-65.952 – RACISM AS A PUBLIC HEALTH THREAT

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious

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

(18) RESOLUTION 008 - INCREASED ACCESS TO HIV TREATMENT AND SUPPORTIVE SERVICES IN THE UNSTABLY HOUSED AND HOMELESS POPULATION

RECOMMENDATION A:

The third Resolve of Resolution 008 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA amend current policy HIV/AIDS as a Global Public Health Priority H-20.922 to state the following
HIV/AIDS as a Global Public Health Priority H-20.922
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, ~~and~~ patient care, <u>and access to stable housing</u> ~~<u>through programs such as Housing Opportunities for Persons with AIDS (HOPWA)</u>~~ for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the

planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
(8) Supports increased availability of and financial assistance for antiretroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic ~~by supporting funding for programs that provide financial assistance to HIV/AIDS patients including but not limited to the AIDS Drug Assistance Program (ADAP)~~; and be it further; and
(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.

RECOMMENDATION B:

Resolution 008 be adopted as amended.

RESOLVED, That our AMA supports the development of regulations and incentives to encourage retention of homeless patients in HIV/AIDS treatment programs; and be it further

RESOLVED, That our AMA recognizes that stable housing promotes adherence to HIV treatment; and be it further

RESOLVED, That our AMA amend current policy HIV/AIDS as a Global Public Health Priority H-20.922 to state the following

HIV/AIDS as a Global Public Health Priority H-20.922
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, ~~and~~ patient care, **and access to stable housing through programs such as Housing Opportunities for Persons with AIDS (HOPWA)** for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;

(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods;
(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions;
(8) Supports increased availability of antiretroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic **by supporting funding for programs that provide financial assistance to HIV/AIDS patients including but not limited to the AIDS Drug Assistance Program (ADAP)**; and be it further ; and
(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.

VRC testimony was mixed. Your Reference Committee agrees with testimony that this resolution addresses a gap in policy because it addresses the intersection between HIV/AIDS and housing insecurity. We agree with testimony requesting that authors strike the specific examples of financial assistance programs/housing programs because if programs cease to exist, the AMA would have to go back and amend our policies. We recommend this resolution be adopted as amended.

(19) RESOLUTION 010 - INCLUSION OF DISABILITY IN MEDICAL STUDENT MISTREATMENT REPORTING

RECOMMENDATION A:

Resolution 010 be amended by addition and deletion to read as follows:

RESOLVED, Our AMA ~~encourages~~ will work with the Association of American Medical Colleges (AAMC) and other relevant bodies to encourage data collection of medical student mistreatment based on disability ~~in parity with other protected categories in medical schools' internal mistreatment surveys and the AAMC Medical School Graduation Questionnaire~~ as a protected category in internal and external mistreatment surveys, including the AAMC Medical School Graduation Questionnaire.

RECOMMENDATION B:

Resolution 010 be adopted as amended.

RESOLVED, Our AMA encourages data collection of medical student mistreatment based on disability in parity with other protected categories in medical schools' internal mistreatment surveys and the AAMC Medical School Graduation Questionnaire.

VRC testimony was supportive and offered clarifying amendments. The Reference Committee agrees with testimony to amend the resolution, specifically in order to make it more actionable by the inclusion of stakeholders and broad by the addition of multiple external mistreatment surveys, including the AAMC Medical School Graduation Questionnaire. We recommend the resolution be adopted as amended.

(20) RESOLUTION 012 - REVISION OF H-185.921, REMOVAL OF AMA SUPPORT FOR ABA

RECOMMENDATION A:

Resolution 012 be amended by the addition of a new second resolved clause to read as follows:

RESOLVED, That our AMA work with relevant stakeholders to advocate for a comprehensive spectrum of primary and specialty care that recognizes the diversity and personhood of individuals who are neurodivergent, including people with autism; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 012 be amended by deletion to read as follows:

RESOLVED, That our AMA amend Policy H-185.921 "Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder" by addition and deletion as follows:

Standardizing Coverage ~~of Applied Behavioral Analysis Therapy~~ Services~~Resources~~ for Persons with Autism Spectrum Disorder, H-185.921 Our AMA supports coverage and reimbursement for evidence-based ~~treatment of~~ services ~~resources~~ for Autism Spectrum Disorder ~~including, but not limited to, Applied Behavior Analysis Therapy~~. ~~and advocates for a more comprehensive spectrum of primary and preventive care to individuals with autism that recognizes the diversity of the neurodivergent community and their personhood.~~

RECOMMENDATION C:

Resolution 012 be adopted as amended.

RESOLVED, That our AMA supports research towards the evaluation and the development of interventions and programs for autistic individuals; and be it further

RESOLVED, That our AMA amend Policy H-185.921 "Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder" by addition and deletion as follows:

Standardizing Coverage ~~of Applied Behavioral Analysis Therapy~~ Resources for Persons with Autism Spectrum Disorder, **H-185.921**

Our AMA supports coverage and reimbursement for evidence-based ~~treatment of~~ resources for Autism Spectrum Disorder ~~including, but not limited to, Applied Behavior Analysis Therapy.~~ and advocates for a more comprehensive spectrum of primary and preventive care to individuals with autism that recognizes the diversity of the neurodivergent community and their personhood.

VRC testimony is supportive of the spirit of the resolution but offered clarifying amendments. The Reference Committee agrees with testimony that advocating “for a more comprehensive spectrum” of care should be separate from the amendment to existing policy regarding coverage and reimbursement. We recommend the addition of a new resolved clause to address this concern. Your Reference Committee recommends Resolution 012 be adopted as amended to include an additional resolved clause and amendments to clarify the removal of ABA support.

(21) RESOLUTION 014 – INCREASED EDUCATION AND ACCESS TO FERTILITY-RELATED RESOURCES FOR U.S. PHYSICIANS

RECOMMENDATION A:

Resolution 014 be amended by addition to read as follows:

RESOLVED, That our AMA-MSS work with appropriate stakeholders to develop gender and sexuality inclusive educational initiatives for medical trainees of all levels to raise awareness about the high rate of physician infertility, family planning options including cryopreservation, and the financial implications of fertility management; and be it further

RESOLVED, That our AMA-MSS urges academic and private hospitals and employers to offer family planning resources and counseling for options such as gamete cryopreservation and in vitro fertilization, for medical residents, fellows, and physicians.

RECOMMENDATION B:

Resolution 014 be adopted as amended.

RESOLVED, That our AMA develop gender and sexuality inclusive educational initiatives for medical trainees of all levels to raise awareness about the high rate of physician infertility, family planning options including cryopreservation, and the financial implications of fertility management; and be it further

RESOLVED, That our AMA urges academic and private hospitals and employers to offer family planning resources and counseling for options such as gamete cryopreservation and in vitro fertilization, for medical residents, fellows, and physicians.

VRC testimony was supportive of the spirit of the resolution, but offered amendments regarding scope. The AMA itself does not create curriculum, so your Reference Committee decided to amend the first resolved clause to ask for collaboration with stakeholders to develop curriculum. Given the upcoming resolution being sent to the AMA House of Delegates on this issue, we decided to make this resolution internal so that we may offer our support in lieu of a duplicative resolution. The Reference Committee recommends Resolution 014 be adopted as amended.

(22) RESOLUTION 015 - SUPPORTING THE USE OF GENDER-NEUTRAL LANGUAGE

RECOMMENDATION A:

The second Resolve of Resolution 015 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA-MSS amend our existing policy and pending transmittal 65.040MSS "Gender Neutral Language in AMA Policy" by addition and deletion as follows:

Gender Neutral Language in AMA Policy, 65.040MSS
Our AMA-MSS will ask our AMA to:
(1) Recognize the importance of using gender-neutral language such as gender-neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity
(2) Rrevise all relevant policies to utilize gender-neutral ~~pronouns and other non-gendered~~ language in place of gendered language where such text inappropriately appears ~~and~~
(3) Uutilize gender-neutral ~~pronouns and other non-gendered~~ language in future policies, internal communications, and external communications where gendered language does not specifically need to be used.
(4) Encourage the use of gender-neutral language in public health and medical messaging~~, including but not limited to messaging put forth by federal organizations such as the Office of the Surgeon General and the U.S. Department of Health and Human Services~~
(5) Encourage other professional societies to utilize gender-neutral language in their work
(6) Support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals

RECOMMENDATION B:

Resolution 015 be adopted as amended.

RESOLVED, That our AMA-MSS amend the title of our existing policy and pending transmittal 65.040MSS "Gender Neutral Language in AMA Policy" to be "Supporting the Use of Gender-Neutral Language"; and be it further

RESOLVED, That our AMA-MSS amend our existing policy and pending transmittal 65.040MSS "Gender Neutral Language in AMA Policy" by addition and deletion as follows:

Gender Neutral Language in AMA Policy, 65.040MSS

Our AMA-MSS will ask our AMA to:

Recognize the importance of using gender-neutral language such as gender-neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity

R~~r~~evise all relevant policies to utilize gender-neutral ~~pronouns and other non-gendered~~ language in place of gendered language where such text inappropriately appears ~~and~~

U~~u~~tilize gender-neutral ~~pronouns and other non-gendered~~ language in future policies, internal communications, and external communications where gendered language does not specifically need to be used~~.~~

Encourage the use of gender-neutral language in public health messaging, including but not limited to messaging put forth by federal organizations such as the Office of the Surgeon General and the U.S. Department of Health and Human Services

Encourage other professional societies to utilize gender-neutral language in their work

Support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals

VRC testimony was supportive. The Reference Committee agrees with testimony to amend the second resolve to request the use of gender-neutral language in AMA, federal, and professional organization's internal/external communications and policies. We recommend adoption of this resolution as amended.

(23) RESOLUTION 016 - AMENDING POLICY H-525.988, "SEX AND GENDER DIFFERENCES IN MEDICAL RESEARCH"

RECOMMENDATION A:

Resolution 016 be amended by addition and deletion to read as follows:

RESOLVED, Our AMA amend Policy H-525.988, "Sex and Gender Differences in Medical Research," by insertion as follows ~~The inclusion of women, and sexual and gender minority participants in clinical research studies and reporting of how the sex and gender of these participants influenced study outcomes requires the cooperation of researchers, federal agencies, and journal editors, which our AMA shall facilitate by amending Policy H-525.988, "Sex and Gender Differences in Medical Research", such that:~~

Sex and Gender Differences in Medical Research, H-525.988

Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;

(2) affirms the need to include ~~both~~ all genders in studies that involve the health of society at large and publicize its policies;

(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; and
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative.
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities ~~recommends that all medical/scientific journals conduct an annual review to assess the quantity and quality of sex- and gender-based research presented~~
(7) ~~supports the creation of a government-sponsored, publicly available online repository that provides centralized access to sex-stratified and gender-stratified data from government-sponsored research, including but not limited to that from the National Institutes of Health, Centers for Disease Control, and Agency of Healthcare Research and Quality~~
(7~~8~~) encourages the FDA to internally develop criteria for identifying ~~and labelling~~ medication and medical devices seeking FDA approval that were developed based on research that did not include adequate participation of women, and sexual and gender minorities.

RECOMMENDATION B:

Resolution 016 be adopted as amended.

RESOLVED, The inclusion of women, and sexual and gender minority participants in clinical research studies and reporting of how the sex and gender of these participants influenced study outcomes requires the cooperation of researchers, federal agencies, and journal editors, which our AMA shall facilitate by amending Policy H-525.988, “Sex and Gender Differences in Medical Research”, such that:

Sex and Gender Differences in Medical Research, H-525.988
Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include ~~both~~ all genders in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women, and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; and

(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative.
(6) recommends that all medical/scientific journals conduct an annual review to assess the quantity and quality of sex- and gender-based research presented
(7) supports the creation of a government-sponsored, publicly available online repository that provides centralized access to sex-stratified and gender-stratified data from government-sponsored research, including but not limited to that from the National Institutes of Health, Centers for Disease Control, and Agency of Healthcare Research and Quality
(8) encourages the FDA to internally develop criteria for identifying and labelling medication and medical devices seeking FDA approval that were developed based on research that did not include adequate participation of women, and sexual and gender minorities

VRC testimony was mixed. Your Reference Committee agrees with testimony that supports the resolution with amendments. We recommend these amendments to address concerns of inclusive language for sexual and gender minorities and feasibility of the resolved clauses. In particular, our amendment to clause 6 was motivated by the authors' compelling VRC testimony regarding the American Geophysical Union's internal audit for gender bias in their peer review process emphasizing the need for diverse peer reviewers. We recommend Resolution 016 be adopted as amended.

(24) RESOLUTION 018 - PROTECTING ACCESS TO ABORTION AND REPRODUCTIVE HEALTHCARE

RECOMMENDATION A:

The first Resolve of Resolution 018 be amended by addition to read as follows:

RESOLVED, That our AMA amends policy H-100.948, "Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Mifepristone (Mifeprex)," by addition and deletion as follows:
~~Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on~~ Supporting Access to Mifepristone (Mifeprex), H-100.948
Our AMA will support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies ~~efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone~~.

RECOMMENDATION B:

Policy H-160.946 be reaffirmed in lieu of the second Resolve of Resolution 018.

RECOMMENDATION C:

The third Resolve of Resolution 018 be amended by addition to read as follows:

RESOLVED, That our AMA amends policy H-5.980, "Oppose the Criminalization of Self-Induced Abortion," by addition and deletion as follows:

Oppose the Criminalization of ~~Self-Induced~~ Abortion, H-5.980
Our AMA: (1) opposes the criminalization of self-~~induced~~ managed abortion and the criminalization of patients who access abortions as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-~~induced~~ managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment,

RECOMMENDATION D:

Resolution 018 be adopted as amended.

RESOLVED, That our AMA amends policy H-100.948, "Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on Mifepristone (Mifeprex)," by addition and deletion as follows:

~~Ending the Risk Evaluation and Mitigation Strategy (REMS) Policy on~~ Supporting Access to Mifepristone (Mifeprex), H-100.948
Our AMA will support mifepristone availability via telemedicine, telehealth, and at retail pharmacies ~~efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone~~.

RESOLVED, That our AMA amends policy H-160.946, "The Criminalization of Health Care Decision Making," by addition as follows:

The Criminalization of Health Care Decision Making, H-160.946
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice and abortion care; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving clinicians who perform abortions and allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

RESOLVED, That our AMA amends policy H-5.980, "Oppose the Criminalization of Self-Induced Abortion," by addition and deletion as follows:

Oppose the Criminalization of ~~Self-Induced~~ Abortion, H-5.980
Our AMA: (1) opposes the criminalization of self-~~induced~~ managed abortion and the criminalization of patients who access abortions as it increases patients'

medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-~~induced~~ managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients.

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

VRC testimony was mixed, with support for adoption as written, support for adoption with amendments, and opposition. Your Reference Committee agrees with testimony to amend the first and third resolved clauses. We agree with the House Coordination Committee (HCC) that the second resolved clause is reaffirmation of existing policy H-160.946. Additionally, we agree with testimony that this resolution should be immediately forwarded. Thus, your Reference Committee recommends Resolution 018 be adopted as amended.

H-160.946 The Criminalization of Health Care Decision Making
The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

(25) RESOLUTION 026 - PROMOTING A FRAGRANCE-FREE HEALTH CARE ENVIRONMENT

RECOMMENDATION A:

The first Resolve of Resolution 026 be amended by deletion to read as follows:

RESOLVED, Our AMA recognizes fragrance sensitivity as a~~n invisible~~ disability where the presence of fragranced products can limit accessibility of healthcare settings; and be it further

RECOMMENDATION B:

The third Resolve of Resolution 026 be amended by deletion to read as follows:

~~RESOLVED, Our AMA encourage places of medical practice to opt for fragrance-free green cleaning products that emit lower levels of volatile organic compounds when possible, and ban the use of scented aerosols or~~

~~fragrance diffusers that do not have a direct disinfectant or medicinal purpose within the facilities; and be it further~~

RECOMMENDATION C:

The fourth Resolve of Resolution 026 be amended by addition and deletion to read as follows:

RESOLVED, Our AMA will work with relevant stakeholders to advocate for governmental regulatory bodies, including but not limited to the Occupational Safety ~~&~~and Health Administration (OSHA), the Centers for Disease Control and Prevention (CDC), and the National Institute for Occupational Safety and Health (NIOSH) to recommend fragrance-free policies in all medical offices, buildings, and places of patient care.

RECOMMENDATION D:

Resolution 026 be adopted as amended.

RESOLVED, Our AMA recognizes fragrance sensitivity as an invisible disability where the presence of fragranced products can limit accessibility of healthcare settings; and be it further

RESOLVED, Our AMA encourages all hospitals, outpatient clinics, urgent cares, and other patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to employees, patients, and visitors of any kind; and be it further

RESOLVED, Our AMA encourage places of medical practice to opt for fragrance-free green cleaning products that emit lower levels of volatile organic compounds when possible, and ban the use of scented aerosols or fragrance diffusers that do not have a direct disinfectant or medicinal purpose within the facilities; and be it further

RESOLVED, Our AMA will work with relevant stakeholders to advocate for the Occupational Safety & Health Administration to recommend fragrance-free policies in all medical offices, buildings, and places of patient care.

VRC testimony was supportive. Your Reference Committee agrees with testimony that the third resolved clause is not supported by evidence in the whereas clauses. Additionally, we agree with testimony that the fourth resolved clause should be broadened to align with evidence and include additional regulatory bodies. The Reference Committee recommends Resolution 026 be adopted as amended.

(26) RESOLUTION 027 – RECOGNIZING THE BURDEN OF RARE DISEASE

RECOMMENDATION A:

Resolution 027 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA recognize the under-treatment and under-diagnosis of orphan diseases, the burden of costs to health care systems

and affected individuals, and the health disparities among patients with orphan diseases; and be it further

RESOLVED, That our AMA support efforts to increase awareness of patient registries, to improve diagnostic and genetic tests, and to incentivize drug companies to develop novel therapeutics to better understand and treat orphan diseases.~~; and be it further~~

~~**RESOLVED, That our AMA encourages the use of national patient registries by clinicians and researchers to gain a more comprehensive and patient-centered understanding of orphan diseases; and be it further**~~

~~**RESOLVED, That our AMA support further efforts for improved diagnostic testing and genomic sequencing efforts to address health disparities in the orphan diseases community.**~~

RECOMMENDATION B:

Resolution 027 be adopted as amended.

RESOLVED, That our AMA recognizes the under-treatment and under-diagnosis of orphan diseases and the burden of costs to health care systems and affected individuals; and be it further

RESOLVED, That our AMA support efforts to incentivize drug companies to develop novel therapeutics to better treat orphan diseases; and be it further

RESOLVED, That our AMA encourages the use of national patient registries by clinicians and researchers to gain a more comprehensive and patient-centered understanding of orphan diseases; and be it further

RESOLVED, That our AMA support further efforts for improved diagnostic testing and genomic sequencing efforts to address health disparities in the orphan diseases community.

VRC testimony was supportive of the resolution with amendments. Your Reference Committee agrees with testimony that the first resolved clause is novel. We agree with concerns surrounding the term “incentivize” in the second resolve clause. We decided to amend Resolution 027 to address the third and fourth resolved clauses within the first and second resolved clauses. Thus, the Reference Committee disagrees with the House Coordination Committee’s decision to place the third and fourth resolved clauses on the reaffirmation calendar. Given that “orphan disease” has a legal definition distinct from “rare disease”, and this resolution was written with the Orphan Disease Act in mind, we preserved this phrasing. We recommend Resolution 027 be adopted as amended.

(27) RESOLUTION 031 - INDIGENOUS DATA SOVEREIGNTY

RECOMMENDATION A:

The Substitute Second Resolve be <u>adopted in lieu of the second Resolve of Resolution 031</u>.

RESOLVED, Our AMA supports that American Indian and Alaska Native (AI/AN) Tribes and Villages' Institutional Review Boards and research departments retain the right to oversee and regulate the collection, ownership, and management of research data generated by their members, and that individual members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research data shared with researchers, AI/AN Tribes and Villages, and governments, consistent with existing protections under 45 CFR 46;

RECOMMENDATION B:

The Substitute Fourth Resolve be <u>adopted in lieu of the fourth Resolve of Resolution 031</u>.

RESOLVED, Our AMA encourages the National Institutes of Health and other stakeholders to provide flexible funding to American Indian and Alaska Native Tribes and Villages for research efforts, including the creation and maintenance of Institutional Review Boards (IRBs).

RECOMMENDATION C:

Resolution 031 be <u>adopted as amended</u>.

RESOLVED, Our AMA recognizes that American Indian and Alaska Native Tribes and Villages are sovereign governments that should be consulted before the conduct of research specific to their members, lands, and properties; and be it further

RESOLVED, Our AMA supports the right of American Indian and Alaska Native Tribes and Villages to govern the collection, ownership, and management of research data generated by their members; and be it further

RESOLVED, Our AMA encourages the use and regular review of data-sharing agreements for all studies between academic medical centers and American Indian and Alaska Native Tribes and Villages; and be it further

RESOLVED, Our AMA amends H-460.921 by addition and deletion:

(Support for Institutional Review Boards H-460.921):
Our AMA: (1) commends the thousands of Institutional Review Board (IRB) members who each have volunteered hundreds of hours annually; (2) urges medical schools, and teaching hospitals to provide IRBs with adequate personnel and other resources to accomplish their mission to safeguard the rights and welfare of human research subjects; and 3) encourages the National Institutes of Health to develop a program that provides flexible funding to institutions **<u>and American Indian and Alaska Native Tribes and Villages</u>**, including support directed at **<u>forming and maintaining</u>** IRBs.

VRC testimony was supportive. The Reference Committee agrees with testimony that the second Resolve should include explicit clarification that the autonomy and privacy of individuals is considered with respect to all parties involved and with respect to the explicit longstanding, established federal protections for human subjects governing all human subjects research, while still giving deference to AI/AN Tribes and Villages' oversight and regulatory authorities. Additionally, we agree with testimony that AI/AN Institutional Review Boards (IRBs) are unique, and their data collection should be kept separate from existing policy relating to medical schools and teaching hospitals in the fourth resolved clause and grouped together with the remaining three resolve clauses of new policy when this resolution is considered in the House of Delegates. Your Reference Committee believes that these amendments capture the intent of the authors as well as address concerns brought up in additional testimony. We recommend this Resolution 031 be adopted as amended.

(28) RESOLUTION 037 - STRENGTHENING INTERVIEW GUIDELINES FOR AMERICAN INDIAN AND ALASKA NATIVE MEDICAL SCHOOL, RESIDENCY, AND FELLOWSHIP APPLICANTS

RECOMMENDATION A:

The first Resolve of Resolution 037 be <u>amended by addition</u> to read as follows:

RESOLVED, Our AMA will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, <u>the Association of American Medical Colleges</u> , and other interested parties to eliminate questioning about or discrimination based on American Indian and Alaska Native blood quantum during the medical school, residency, and fellowship application process.

RECOMMENDATION B:

Resolution 037 be <u>adopted as amended</u>.

RESOLVED, Our AMA will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on American Indian and Alaska Native blood quantum during the medical school, residency, and fellowship application process.

VRC testimony was supportive. Your Reference Committee agrees with testimony that this resolution is not a reaffirmation of existing policy. We recommend adoption of this resolution as amended with the addition of the Association of American Medical Colleges (AAMC) as a stakeholder.

(29) RESOLUTION 040 - PROTECTING WORKERS DURING CATASTROPHES

RECOMMENDATION A:

The first Resolve of Resolution 040 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA will ~~advocate for~~ support legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes; and be it further

RECOMMENDATION B:

The second Resolve of Resolution 040 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA will ~~advocate that~~encourage the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate stakeholders to develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment and traveling to and from their place of employment during catastrophes.

RECOMMENDATION C:

Resolution 040 be adopted as amended.

RESOLVED, That our AMA will advocate for legislation that creates federal standards of safety and protection of workers during catastrophes; and be it further

RESOLVED, That our AMA will advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate stakeholders to develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment and traveling to and from their place of employment during catastrophes.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the amendment to the first Resolve is important to align language with Federal Emergency Management Agency (FEMA) definitions ("natural or man-made"). The Reference Committee does not agree with suggestions to specify "environmental" catastrophe in the first resolved clause, and found the complete FEMA definition of catastrophe from author's amended language to be unnecessary. We recommend that Resolution 040 be adopted as amended.

(30) RESOLUTION 052 - PROMOTING ALGORITHMIC STEWARDSHIP IN HEALTHCARE SYSTEMS

RECOMMENDATION A:

Policy D-350.981 be reaffirmed in lieu of the first Resolve of Resolution 052.

RECOMMENDATION B:

The third Resolve of Resolution 052 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support the development of ~~works with appropriate stakeholders to develop~~ criteria for premarket assurance of safety and effectiveness of augmented intelligence technology that requires a data quality check ensuring datasets are made of diverse patient populations, addressing bias, and mitigating healthcare disparities.~~; and be it further,~~

RECOMMENDATION C:

Policy H-480.940 be reaffirmed in lieu of the fourth Resolve of Resolution 052.

RECOMMENDATION D:

Resolution 052 be adopted as amended.

RESOLVED, That our AMA support Algorithmic Stewardship in hospital systems, either as a multidisciplinary team, or individuals to monitor inequitable algorithmic decision making; and be it further

RESOLVED, That our AMA works with appropriate stakeholders to support creation of training modules highlighting the dangers of algorithmic bias and preventative measures for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research utilizing augmented intelligence; and be it further

RESOLVED, That our AMA works with appropriate stakeholders to develop criteria for premarket assurance of safety and effectiveness of augmented intelligence technology that requires a data quality check ensuring datasets are made of diverse patient populations, addressing bias, and mitigating healthcare disparities; and be it further,

RESOLVED, That our AMA support post-approval surveillance measures, including but not limited to requiring technology firms and health care systems to regularly audit any algorithms that influence patient care utilizing frameworks developed by appropriate regulatory agencies.

VRC testimony was split. Your Reference Committee agrees with testimony that the first and fourth Resolves are reaffirmation of existing policy and are not novel as written. We recommend that the second Resolve should be removed from the House Coordination Committee's reaffirmation consent calendar because it is novel and within the AMA's scope. We agree with testimony that the third Resolve should be amended to fit within the scope of the AMA by changing the action from "work with" to "support." The Reference Committee recommends this resolution be adopted as amended.

(31) GC REPORT A – REVIEW OF MSS SUNSET MECHANISM AND PROCESS

RECOMMENDATION A:

The Recommendation of GC Report A be amended by deletion to read as follows:
That AMA-MSS policy 630.044MSS, Sunset Mechanism for AMA-MSS Policy, be amended by addition and deletion as follows:

AMA-MSS will establish and use a sunset mechanism for AMA-MSS policy with a five-year time horizon whereby a policy will remain viable for five years unless action is taken by the Assembly to reestablish or refer it. The implementation of a sunset mechanism for AMA-MSS policy shall follow the following procedures: (1) review of policies will be the ultimate responsibility of the Governing Council, whereby the report is authored by the Chair of the Governing Council with initial policy recommendations being solicited from relevant Standing Committees as appropriate; (2) The Governing Council will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset; (3) policy recommendations will be reported to the AMA-MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption, with a brief rationale accompanying each recommendation; (34) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (45) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism unless referred back to the Governing Council; ~~and (6) policies solely reaffirming existing AMA policy shall be sunset by default unless otherwise recommended for retention.~~

RECOMMENDATION B:

GC Report A be amended by addition of a new Recommendation to read as follows:

That the Governing Council study whether policies solely reaffirming existing AMA policy should be sunset by default unless otherwise recommended for retention.

RECOMMENDATION C:

Recommendations in GC Report A be adopted as amended and the remainder of the report be filed.

Your MSS Governing Council recommends:

That AMA-MSS policy 630.044MSS, Sunset Mechanism for AMA-MSS Policy, be amended by addition and deletion as follows:

AMA-MSS will establish and use a sunset mechanism for AMA-MSS policy with a five-year time horizon whereby a policy will remain viable for five years unless action is taken by the Assembly to reestablish or refer it. The implementation of a sunset mechanism for AMA-MSS policy shall follow the following procedures: (1) review of policies will be the ultimate responsibility of the Governing Council, whereby the report is authored by the Chair of the Governing Council with initial

policy recommendations being solicited from relevant Standing Committees as appropriate; (2) The Governing Council will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset; (3) policy recommendations will be reported to the AMA-MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption, with a brief rationale accompanying each recommendation; (34) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (45) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism unless referred back to the Governing Council; and (6) policies solely reaffirming existing AMA policy shall be sunset by default unless otherwise recommended for retention.

VRC testimony was mixed, but limited. Your Reference Committee agrees with testimony that the first five parts of the recommendation are well-supported and adequately address concerns related to the sunset process, and we recommend adoption. However, VRC testimony opposed the sixth clause. We agree that the ask of the sixth clause does not have as much support from the rest of the report and that a more in-depth review process should be developed to prevent unintended sunsetting by default. We encourage further study of the implications and consequences of this change by a MSS Standing Committee such as the Committee on Long Range Planning. We therefore recommend further study of the sixth clause of the recommendation of GC Report A. Your Reference Committee recommends GC Report A be adopted as amended and the remainder of the report be filed.

(32) MIC REPORT A - ADDRESSING HEALTH INSURANCE COVERAGE DISPARITY AMONG LATINX CHILDREN

RECOMMENDATION A:

The Recommendation of MIC Report A be amended by addition and deletion to read as follows:

Your AMA-MSS Minority Issues Committee Standing Committee recommends that the following recommendations are ~~not~~ adopted as amended~~due to reaffirmation of existing policy~~ and the remainder of this report is filed:

1. That our AMA advocate for the removal of eligibility criteria based on ~~citizenship~~ immigration status from Medicaid and CHIP.

RECOMMENDATION B:

The Recommendation of MIC Report A be adopted as amended and the remainder of the report be filed with a title change:

Title: "Immigration Status in Medicaid & CHIP"

Your AMA-MSS Minority Issues Committee Standing Committee recommends that the following recommendations are not adopted due to reaffirmation of existing policy and the remainder of this report is filed:

1. That our AMA advocate for the removal of eligibility criteria based on citizenship status from Medicaid and CHIP.

VRC testimony was supportive. Your Reference Committee agrees with testimony that opposes reaffirmation of existing policy in lieu of the original Resolution 021. We recommend reversal of the report's recommendation to not adopt and instead recommend adopting the recommendation of the report as amended. Additionally, we agree with testimony to amend the recommendation to specify "the removal of eligibility criteria based on immigration status" because removing restrictions based on citizenship status would be insufficient. Therefore, the Reference Committee recommends the recommendations of MIC Report A be adopted as amended and the remainder of the report be filed. Additionally, we recommend a title change to clarify the title based on the recommended amendments.

(33) CSI CGPH REPORT A - ADDRESSING INEQUITY IN ONSITE WASTEWATER TREATMENT

RECOMMENDATION A:

CSI CGPH Report A be <u>amended</u> by addition of a new first resolved clause to read as follows:

<u>RESOLVED, That our AMA supports that federal, state, and local governments abate financial and criminal penalties for insufficient wastewater management, especially those placed on underserved communities due to environmental racism and socioeconomic disparities; and be it further</u>

RECOMMENDATION B:

The second Resolve of CSI CGPH Report A be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA supports research <u>by</u> ~~into~~ federal, state, and local governments to develop strategies <u>to</u>~~for~~ reduc<u>e</u>~~ing~~ insufficient wastewater management <u>and eliminate detrimental health effects due to inadequate wastewater systems</u>.

RECOMMENDATION C:

The Recommendations of CSI CGPH Report A be <u>adopted as amended</u> and the remainder of the report be filed.

RESOLVED, That our AMA supports research into federal, state, and local governments to develop strategies for reducing insufficient wastewater management.

VRC testimony was mixed. Your Reference Committee agrees with testimony to add the first resolved clause to align with the intent of the report. We recommend the recommendations of CSI CGPH Report A be adopted as amended and the remainder of the report be filed.

(34) CAIA REPORT B - AMENDING POLICY ON PUBLIC OPTION TO MAXIMIZE AMA ADVOCACY

RECOMMENDATION A:

The Recommendation of CAIA Report B be amended by addition and deletion to read as follows:

Our AMA will advocate that physicians at Indian Health Service, Tribal, and Urban Indian Health Programs be exempt from duplicative licensure requirements, such as requirements for state licensure when these physicians are already federally licensed.~~for a single licensing standard for physicians employed at Indian Health Service facilities that exempt them from state licensing requirements in their respective state of practice.~~

RECOMMENDATION B:

CAIA Report B be amended by addition of a new Recommendation to read as follows:

Our AMA will advocate that future health reform proposals include corresponding licensure and eligibility exceptions for Indian Health Service, Tribal, and Urban Indian Health Program facilities and physicians to ensure that these physicians can fully participate.

RECOMMENDATION C:

The Recommendations of CAIA Report B be adopted as amended and the remainder of the report be filed with a title change.

Title: "Indian Health Service Licensure Exemptions"

Your Committee on American Indian Affairs recommends that the following recommendations are adopted, and the remainder of this report is filed:

Our AMA will advocate for a single licensing standard for physicians employed at Indian Health Service facilities that exempt them from state licensing requirements in their respective state of practice.

VRC testimony was supportive of the report recommendations. The Reference Committee agrees with testimony to support a single licensing standard and we amended the first resolve to more explicitly state this and broaden the language to be inclusive of all duplicative licensure requirements. The recommended addition of a second resolved clause was done to make sure that future health reform includes the exceptions outlined in the report, to preempt the issues that occurred during the Affordable Care Act's passage requiring a separate amendment for these exceptions.

Your Reference Committee recommends the recommendations of CAIA Report B be adopted and the remainder of the report be filed. Additionally, we recommend a title change to accurately reflect the intent of the resolved clauses.

(35) CSI REPORT A - ADVOCATING FOR PLANT-BASED MEAT RESEARCH AND REGULATION

RECOMMENDATION A:

The first Resolve of CSI Report A be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~supports~~ works with appropriate stakeholders to ~~advocate for~~ support plant-based meat research funding.~~; and be it further~~

RECOMMENDATION B:

The Recommendations of CSI Report A be adopted as amended and the remainder of the report be filed with a title change:

Title: "Support for Research on Plant-Based Meat"

Your Committee on Scientific Issues recommends that Resolution 065 be adopted as amended by insertion and deletion, and the remainder of this report be filed:

1. RESOLVED, That our AMA ~~supports~~ works with appropriate stakeholder to advocate for plant-based meat research funding.~~; and be it further~~

2. ~~RESOLVED, That our AMA supports federal regulation and oversight of plant-based meat producers.~~

VRC testimony was supportive and offered amendments. Your Reference Committee agrees with testimony to change the action of the first resolved clause from "advocate" to "support" to avoid a higher fiscal note, noting specific rationale for the change was not provided in the report. We recommend that the recommendations of CSI Report A be adopted as amended and the remainder of the report be filed. Additionally, we recommend a title change to reflect the verbiage of the amended resolved clause.

(36) COLA CGPH REPORT A - REDUCING BURDEN OF INCARCERATION ON PUBLIC HEALTH

RECOMMENDATION A:

The second Resolve of COLA CGPH Report A be amended by addition and deletion to read as follows:

RESOLVED, That our AMA partner with the American Public Health Association and other stakeholders to urge Congress, the Department of Justice, and the Department of Health & Human Services ~~the Centers for Disease Control and Prevention, and the National Institutes of Health~~ to

minimize the negative health effects of incarceration ~~via support for programs to facilitate access to housing and employment after release from incarceration~~ by supporting efforts to pilot evidence-based alternatives to incarceration that maintain public safety.

RECOMMENDATION B:

The Recommendations of COLA CGPH Report A be adopted as amended and the remainder of the report be filed.

Your Committee on Legislation and Advocacy and Committee on Global and Public Health recommend that the following resolve clauses be adopted in lieu of the original resolution and the remainder of the report be filed:

RESOLVED, That our AMA support efforts to reduce the negative health impacts of incarceration, such as

1) implementation and incentivization of adequate funding and resources towards indigent defense systems;
2) implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records;
3) housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings; and be it further

RESOLVED, That our AMA partner with the American Public Health Association and other stakeholders to urge Congress, the Centers for Disease Control and Prevention, and the National Institutes of Health to minimize the negative health effects of incarceration via support for programs to facilitate access to housing and employment after release from incarceration.

VRC testimony was supportive. The Reference Committee recommends amending the language of the second resolved clause to add phrases from the original Resolution 046 that are aspirational and broad regarding the actions that stakeholders can take. We recommend the recommendations of this report be adopted as amended and the remainder of the report be filed.

(37) CEQM REPORT A - STUDYING POPULATION-BASED INSURANCE AND PAYMENT POLICY DISPARITIES

RECOMMENDATION A:

The second Resolve of CEQM Report A be amended by addition to read as follows:

RESOLVED, That our AMA-MSS support addressing potential insufficiencies in coding and disparities in reimbursement for historically underserved populations including, but not limited to, categorization of services performed by gender, race, ethnicity, ability, or age of the patient.

RECOMMENDATION B:

CEQM Report A be amended by addition of a new Recommendation to read as follows:

RESOLVED, Our AMA study possible disparities in physician reimbursement for health services primarily provided to women and sexual and gender minorities, children, elder patients, patients with disabilities, and other underserved populations and subsequent effects on physician income, especially in specialties that primarily serve those populations.

RECOMMENDATION C:

The Recommendations of CEQM A be adopted as amended and the remainder of the report be filed.

The Committee on Economics and Quality in Medicine recommends that the following policy be adopted and the remainder of the report filed:

RESOLVED, That our AMA-MSS supports existing AMA policy H-65.961 Principles for Advancing Gender Equity in Medicine given its principles of equitable compensation; and be it further

RESOLVED, That our AMA-MSS support addressing potential insufficiencies in coding and disparities in reimbursement for historically underserved populations including, but not limited to, categorization by gender, race, ethnicity, ability, or age.

RESOLVED, That our AMA-MSS support addressing insufficiencies in coding and relative valuation for care that may lead to disparities in reimbursement for physicians treating underserved populations, including but not limited to increasing diversity and representation on appropriate decision-making bodies.

VRC testimony was supportive. We thank the MSS Committee on Economics & Quality in Medicine for an excellent report on a very complex issue. Your Reference Committee recommends amendments to the second resolve clause to clarify the language. We agree with testimony that supports the internal asks of the report recommendations. Additionally, we recommend the addition of a fourth resolved clause to ask for direct AMA action, which we felt was justified by the report's evidence that this issue exists. We recognize that the original resolution's language may have been too prescriptive and direct in its asks and possible interference with the processes of specific stakeholders, but we believe that a more general AMA report on the issue could glean useful information. While we agree that MSS internal policy on this issue is useful, we believe that action on this issue from AMA is unlikely without a direct attempt to at least open a conversation. The Reference Committee recommends the recommendations be adopted as amended and the remainder of the report be filed.

(38) CGPH CBH REPORT A - OPPOSING USE OF VULNERABLE INCARCERATED PEOPLE IN RESPONSE TO PUBLIC HEALTH EMERGENCIES OF INFECTIOUS DISEASE ORIGIN

RECOMMENDATION A:

The second Resolve of CGPH CBH Report A be amended by addition and deletion to read as follows:

RESOLVED, That our AMA supports that any labor performed by incarcerated individuals or other captive populations should include ~~(1)~~ adequate workplace safety and fairness standards similar to those outside of carceral institutions and support their reintegration into the workforce after incarceration ~~and (2) transferable skills or tangible value in reintegrating into the workforce~~.

RECOMMENDATION B:

The Recommendations of CGPH CBH Report A be adopted as amended and the remainder of the report be filed.

Your Committee on Global and Public Health and Committee on Bioethics and Humanities recommend that the following alternate resolution be adopted in lieu of MSS Resolution 013:

RESOLVED, That our AMA opposes the use of forced or coercive labor practices for incarcerated populations; and be it further

RESOLVED, That our AMA supports that any labor performed by incarcerated individuals or other captive populations should include (1) adequate workplace safety and fairness standards similar to those outside of carceral institutions and (2) transferable skills or tangible value in reintegrating into the workforce.

VRC testimony was limited. We agree with testimony that this report is well-written and addresses a gap in existing policy. We recommend an amendment to the second resolve clause to emphasize that the intent of any labor should support reintegration , especially since “transferable skills or tangible value” may be variably defined by those that exploit the labor of incarcerated individuals. Your Reference Committee recommends the report be adopted as amended.

(39) CDA CME REPORT A – EXPANDING SUPPORT FOR MEDICAL STUDENTS AND PHYSICIANS WITH DISABILITIES

RECOMMENDATION A:

The first Resolve of CDA CME Report A be amended by addition to read as follows:

RESOLVED, That our AMA-MSS will prioritize the input, direction, and partnership of members with personal and lived experience of disability, especially those with intersecting marginalized identities, to ensure those most impacted guide the direction of change; and be it further

RECOMMENDATION B:

The fourth Resolve of CDA CME Report A be referred to study.

RECOMMENDATION C:
The Recommendations of CDA CME Report A be adopted as amended and the remainder of the report be filed.

Your Committee on Disability Affairs and Committee of Medical Education recommends that the following recommendations for LR 001 are adopted as amended and the remainder of this report is filed:

RESOLVED, That our AMA will prioritize the input, direction, and partnership of members with personal and lived experience of disability, especially those with intersecting marginalized identities, to ensure those most impacted guide the direction of change; and be it further

1. ~~RESOLVED, That our AMA will collaborate with the relevant testing institutions to study and report back on the present barriers for applicants, medical students, and physicians with disabilities regarding admission, curricular, and licensing exams, and recommended practices that improve accessibility for and inclusion of those with disabilities; and be it further~~

2. ~~RESOLVED, That our AMA will study and report back on persisting barriers to employment for physicians with disabilities, and recommend hiring and workplace practices (e.g. experienced disability service offices) that improve accessibility for and inclusion of those with disabilities; and be it further~~

RESOLVED, That our AMA will collaborate with the Association of American Medical Colleges and The Coalition for Disability Access in Health Science Education to develop national standards for disability service providers (DSPs) that serve medical students, residents, and physicians, to ensure consistent training, practices, and availability of healthcare-specific DSPs.

VRC testimony opposed the report recommendations as written. Your Reference Committee agrees with testimony that the first resolved clause is not supported by enough research and so we recommend an amendment to make this clause internal to the AMA-MSS. We agree with testimony that the fourth resolved clause should be referred because the AMA is not the appropriate organization to develop national standards. The Reference Committee recommends adoption of the first Resolve as internal policy and referral of the fourth resolved clause.

RECOMMENDED FOR ADOPTION IN LIEU OF

(40) RESOLUTION 001 - OPPOSING THE CENSORSHIP OF SEXUALITY AND GENDER IDENTITY DISCUSSIONS IN PUBLIC SCHOOLS

RECOMMENDATION:

Substitute Resolution 001 be adopted in lieu of Resolution 001:

RESOLVED, That our AMA opposes censorship of LGBTQIA+ topics and opposes any policies that limit discussion or restricts mention of sexuality, gender identity and the LGBTQIA+ human experience in schools or educational curricula; and be it further

RESOLVED, That our AMA will support policies that ensure an inclusive, well-rounded education free from censorship of discussions surrounding sexuality and gender identity in public schools.

RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the June 2022 Meeting.

RESOLVED, That our AMA opposes censorship of information about LGBTQIA+ issues and any legislation that similarly harms LGBTQIA+ youth and reduces health literacy; and be it further

RESOLVED, That our AMA will support legislation that ensures an inclusive, well-rounded education free from censorship of discussions surrounding sexuality and gender identity in public schools.

VRC testimony was supportive of the resolution with friendly amendments. The Reference Committee agrees with testimony that clarifies the intent of the first resolved clause. Additionally, we agree with testimony from The Gay and Lesbian Medical Association (GLMA) that this resolution should be immediately forwarded to the AMA House of Delegates. Your Reference Committee recommends a substitute resolution be adopted in lieu of Resolution 001 to clarify the resolved clauses and add an immediate forwarding clause.

(41) RESOLUTION 003 - ACCESSIBLE ELECTRONIC CHARTING SOFTWARE AND ALTERNATIVE ACCESS TO HEALTH INFORMATION FOR VISUALLY IMPAIRED PATIENTS

RECOMMENDATION:

Substitute Resolution 003 be adopted in lieu of Resolution 003.

RESOLVED, That our AMA strongly urge electronic health record companies to improve their software to be accessible for patients with visual impairments without requiring them to use third-party programs.

RESOLVED, That our AMA will work with relevant organizations and digital healthcare communication companies to improve the accessibility of electronic charting software that allows visually impaired and blind patients to review and receive health information independently without the use of third-party software in order to maintain privacy; and be it further

RESOLVED, That our AMA will encourage hospitals and clinics without accessible healthcare software for the visually impaired to adopt policies for patients that allow them to communicate with healthcare providers in order to review and receive test results, health charts, and medical information independently.

VRC testimony was supportive of this resolution. The Reference Committee agrees with testimony that Resolution 003 addresses a gap in current policy. We believe that the AMA should work with electronic health record companies directly instead of relevant organization as outline in the first resolve. Additionally, we believe the second resolve is an intuitive ask that is not well-supported by the whereas clauses. Thus, your Reference Committee recommends adopting Substitute Resolution 003 in lieu of Resolution 003.

(42) RESOLUTION 007 - INTERRUPTED PATIENT SLEEP

RECOMMENDATION:

Substitute Resolution 007 be <u>adopted in lieu of Resolution 007.</u>

RESOLVED, Our AMA will work with relevant stakeholders, including the American Hospital Association (AHA), to evaluate current patient sleep interruption practices and develop strategies to minimize excessive patient sleep interruptions.

RESOLVED, Our AMA urges hospital administration to evaluate current patient sleep guidelines and decrease the number of nightly interruptions.

VRC testimony was mixed. The Reference Committee agrees with concerns surrounding the feasibility of the resolution's ask. We agree with testimony that sleep guidelines are not well-established and recommend a substitute resolution to better align the ask with evidence from the whereas clauses. Your Reference Committee recommends adoption of a substitute resolution in lieu of Resolution 007 to offer a more evidence-based solution.

(43) RESOLUTION 009 - ADDRESSING THE USE OF MAIL-ORDER NALOXONE TO CURB THE OPIOID EPIDEMIC

RECOMMENDATION:

Substitute Resolution 009 be <u>adopted in lieu of Resolution 009 with a title change.</u>

Title: "Support for Mail-Order Naloxone"

RESOLVED, That our AMA supports efforts to increase the availability, delivery, possession and use of mail-order Naloxone to help prevent opioid-related overdose, especially in underserved communities.

Resolved, Our AMA supports the development of infrastructure that allows for the administration of mail-order Naloxone for the treatment of opioid use disorder where this practice is underutilized, particularly in rural and Tribal areas.

VRC testimony was supportive of the spirit of the resolution, and was split between adoption and reaffirmation. Your Reference Committee agrees with testimony that the resolution addresses a gap in existing policy because Resolution 009 addresses mail-order naloxone as a method for delivery. However, we have concerns with the actionability of the language as written, given that the AMA typically cannot create infrastructure in this capacity. We also share concerns that listing specific groups may unintentionally limit access for underserved urban communities. We recommend this substitute resolution be adopted in lieu of Resolution 009 with a title change.

(44) RESOLUTION 013 - DISMANTLING HOMELESSNESS BRICK BY BRICK - AN EVICTION & RATE-CENTERED ACTION TO PREVENT HOMELESSNESS

RECOMMENDATION:

Substitute Resolution 013 be <u>adopted in lieu of Resolution 013</u>.

RESOLVED, That our AMA-MSS change the title of our current transmittal "Amending H-160.903, Eradicating Homelessness to Include Support for Street Medicine Programs" to read "Amending H-160.903, Eradicating Homelessness to Include Support for Street Medicine Programs and Reduce Evictions"

RESOLVED, That our MSS amend our pending transmittal, "Amending H-160.903, Eradicating Homelessness to Include Support for Street Medicine Programs" by addition and deletion to read as follows:
Eradicating Homelessness, H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
<u>(4) supports the use of street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;</u>

(~~4~~5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(~~5~~6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(~~6~~7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(~~7~~8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(~~8~~9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(~~9~~10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(~~10~~11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.~~.~~; and
(12) supports federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants' right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries.

RESOLVED, That our American Medical Association (AMA) supports evidence-based approaches for combating homelessness, such as but not limited to:

(1) an overhaul of local eviction laws in states that have unfair and power laden eviction policies;
(2) rent control that would limit the ability of landlords to increase rents annually by more than a moderate sum tied to inflation with vacancy decontrol,
(3) just cause eviction statutes;
(4) access to legal representation for individuals confronted with eviction;
(5) the creation of local, state, and/or national rental registries; and
(6) other proven methods[13,20,21]; and be it further

RESOLVED, That our AMA amend their current policy to reduce the prevalence of homelessness in the context of socioeconomic implications of public health crises and/or emergencies (i.e., housing crisis, unregulated rental inflation, and instability of the certain job sectors particularly employed by low income and minority individuals), Policy 440.060MSS, "Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States" by addition and deletion to read as follows:

Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States, 440.060MSS
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing, and appropriate voluntary social services as a first priority in the treatment of chronically homeless individuals, without mandated therapy or services compliance; and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness; and (4) supports policy, including but not limited to, which endorses the restructuring of unfair and power laden eviction policies, inflation-based rent control, just cause eviction statutes, right to counsel, local, state, and/or national rental registries, and other evidence-based measures (MSS Res 38, I-16) (AMA Res 208, A-17 Referred) (Reaffirmed: MSS GC Report A, I-21); and be it further

RESOLVED, That our AMA amend their current policy to reduce the prevalence of homelessness in the context of socioeconomic implications of public health crises and/or emergencies (i.e., housing crisis, unregulated rental inflation, and instability of the certain job sectors particularly employed by low income and minority individuals), Policy H-160.903, “Eradicating Homelessness” by addition and deletion to read as follows:

Eradicating Homelessness, H-160.903
Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other

stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.; and
(11) advocates for an overhaul of local eviction laws in states that have unfair and power laden eviction policies, inflation-based rent control, just cause eviction statutes, right to counsel, and creation of local, state, and/or national rental registries to reduce the prevalence of homelessness; and be it further

RESOLVED, That our AMA amend their current policy to reduce the prevalence of homelessness in the context of socioeconomic implications of public health crises and/or emergencies (i.e., housing crisis, unregulated rental inflation, and instability of the certain job sectors particularly employed by low income and minority individuals), Policy D-440.920, "Support for the Prevention of Eviction and the Termination of Life-Essential Utility Services During Public Health Emergencies" by addition and deletion to read as follows:

Support for the Prevention of Eviction and the Termination of Life-Essential Utility Services During Public Health Emergencies, D-440.920
Our AMA will advocate for: (1) policies that prevent evictions during public health emergencies; and (2) prevention of termination of life-essential utilities during public health emergencies; and (3) policies that reduce evictions and homelessness including but not limited to the overhaul of highly punitive eviction policies, inflation-based rent control, just cause eviction statutes, right to counsel, and local, state, and/or national rental registries; and be it further

RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the June 2022 Meeting.

VRC testimony was supportive. The Reference Committee agrees with amendments to incorporate this resolution into a current pending MSS transmittal that seeks to amend Eradicating Homelessness, H-160.903. We concluded that the immediate forwarding clause is not needed because of the pending transmittal. Your Reference Committee recommends the adoption of a substitute resolution in lieu of Resolution 013.

(45) RESOLUTION 020 - ADOPTION OF ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT STANDARDS

RECOMMENDATION A:

Substitute Resolution 020 be adopted in lieu of Resolution 020.

RESOLVED, That our AMA study the optimal ways to enforce proposed federal accessibility standards for medical diagnostic equipment, with report back by the 2023 Annual Meeting of the House of Delegates.

RESOLVED, Our AMA supports the formal adoption of enforceable accessibility standards for Medical Diagnostic Equipment.

VRC testimony was mixed. Your Reference Committee agrees that adoption of accessibility standards is necessary, but also agrees with testimony that it is unclear who will pay for the cost of meeting new Medical Diagnostic Equipment (MDE) standards. As it remains unclear how to transition to those standards with minimal harm done to small and privately-owned practices, more research is needed. We recommend a substitute resolution be adopted in lieu of Resolution 020 refer the item for an external AMA study with report back at time certain, given the possibility of pending regulations in the next one to two years, and clarify the financial implications and the enforcement of proposed MDE standards.

(46) RESOLUTION 022 - ACCURACY AND AWARENESS FOR SEX REPRESENTATION IN MEDICAL TEXTBOOKS

RECOMMENDATION A:

Policy D-295.310 and H-525.976 be <u>reaffirmed in lieu of the second Resolve of Resolution 022</u>.

RECOMMENDATION B:

Substitute Resolution 022 be <u>adopted in lieu of the remainder of Resolution 022 with a title change</u>.

Title: "Accuracy of Sex & Gender Representation in Medical Educational Materials"

RESOLVED, That our AMA support that medical textbooks and other medical educational materials equitably, accurately, and comprehensively represent people across the spectra of gender identity and phenotypic sex, especially cisgender women and sexual and gender minorities; and be it further

RESOLVED, That our AMA support that anatomic images in medical textbooks and other medical educational materials represent the diversity and variations of human anatomy, in the contexts of both sexual physiology and other organ physiology.

RESOLVED, Our AMA supports increased female sex, intersex, and transgender representation in medical textbooks including anatomical images in sex specific and nonspecific content; and be it further

RESOLVED, Our AMA recognizes the need for accurate depictions of female sex anatomy including the clitoris and vulva length, morphology, nerves, and vasculature, and variations in medical textbooks.

VRC testimony was supportive of the spirit of the resolution but with amendments. The Reference Committee agrees with the House Coordination Committee (HCC) that the second resolved clause is reaffirmation of existing policies D-295.310 and H-525.976. We agree with testimony to expand the language to include all medical educational materials and recommend a substitute resolution to further clarify the intent of equitable representation. Your Reference Committee recommends adoption of a substitute resolution in lieu of Resolution 022.

D-295.310 Sex and Gender Based Medicine in Clinical Education
1. Our AMA will collaborate with Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to disseminate the work produced by medical schools participating in the Accelerating Change in Medical Education consortium and distribute pertinent information and a comprehensive bibliography about the influence that sex and gender have upon clinical medicine.
2. Our AMA will work collaboratively with the Liaison Committee on Medical Education and other interested organizations for the inclusion of sex- and gender-based differences within the curricular content for medical school accreditation.

H-525.976 An Expanded Definition of Women's Health
Our AMA recognizes the term "women's health"□ as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.

(47) RESOLUTION 024 - REFORMING THE FDA ACCELERATED APPROVAL PROCESS

RECOMMENDATION A:

Substitute Resolution 024 be <u>adopted in lieu of Resolution 024</u>.

RESOLVED, Our AMA study potential mechanisms to address issues in the Food & Drug Administration's Accelerated Approval process, which may include ameliorating delays in post-marketing confirmatory study timelines, expiration dates for accelerated approvals, withdrawal of approvals when post-marketing studies fail, justifications for the use of surrogate endpoints used to demonstrate clinical benefit, and special considerations for certain diseases.

RESOLVED, Our AMA supports ongoing efforts to clarify regulations regarding the Food and Drug Administration's Accelerated Approval process to 1) set explicit standards for the enrollment and completion timeline of post-marketing confirmatory studies prior to the granting of accelerated approval to avoid the persistent delays observed with post-marketing trials to date 2) introduce standardized expiration dates for accelerated approvals to significantly ease the process of withdrawing drugs for which post-marketing studies fail and 3) set explicit guidelines for the endpoints used in confirmatory studies to ensure that confirmatory studies demonstrate clinical benefit.

RESOLVED, Our AMA supports granting the Food and Drug Administration flexibility to grant exemptions to new standards for post-marketing surveillance if the agency determines that the nature of the disease indication prevents a sponsor from acting in accordance with the established standards.

VRC testimony was split between those supporting and those offering amendments. Your Reference Committee thanks the authors for bringing this important issue forward and agrees with VRC testimony that the resolution would benefit from further external study by the AMA to make recommendations on how they would proceed in this complex regulatory space, with the explicit suggestions included in the language here for possible issues to address. We recommend Substitute Resolution 024 be adopted in lieu of Resolution 024.

(48) RESOLUTION 030 - SNAP EXPANSION FOR DACA RECIPIENTS

RECOMMENDATION A:

Substitute Resolution 030 be <u>adopted in lieu of Resolution 030</u>.

RESOLVED, That our AMA will actively support expansion of SNAP to Deferred Action Childhood Arrivals (DACA) recipients who would otherwise qualify.

RESOLVED, our AMA will amend Resolution D-440.927, Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services, by insertion to read as follows:

Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services, D-440.927

1. Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.
2. Our AMA will actively support expansion of SNAP to Deferred Action Childhood Arrivals (DACA) recipients.

VRC testimony supports the novelty of the resolution. Your Reference Committee agrees with VRC concerns that the resolves did not specify if the AMA should support expanding SNAP to all DACA recipients or just those who would qualify for SNAP. We therefore recommend adoption of substitute language in lieu of Resolution 030.

(49) RESOLUTION 035 - FDA INDICATIONS FOR OFF-LABEL & OVER-THE-COUNTER DRUGS

RECOMMENDATION:

Substitute Resolution 035 be <u>adopted in lieu of Resolution 035 with a title change</u>.

Title: “Comparative Effectiveness Research”

RESOLVED, That our AMA study the feasibility of including comparative effectiveness studies in various FDA drug regulatory processes, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter; and be it further

RESOLVED, That our AMA ask the National Institutes of Health to support and fund comparative effectiveness research for approved drugs, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter.

RESOLVED, That our AMA ask the Food & Drug Administration (FDA) to consider reforms to the investigational new drug (IND) approval process, such that clinical trials compare INDs to widely available structurally similar drugs with reasonable evidence-based likelihood of benefit for the same purpose, especially generics, biosimilars, and drugs used off-label or over-the-counter; and be it further

RESOLVED, That our AMA ask the National Institutes of Health to support and fund research comparing already approved medications to widely available structurally similar drugs with reasonable evidence-based likelihood of benefit for the same clinical purpose, especially generics, biosimilars, and drugs used off-label or over-the-counter.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the first Resolve should be amended to request an external study to examine the nuances of the FDA's processes. Additionally, we agree with testimony that the language of the second Resolve can be clarified to reflect the intent. We support this substitute resolution put forward by the authors to be adopted in lieu of Resolution 035. Lastly, the title change reflects the clarified intent of the resolution.

(50) RESOLUTION 033 - REFORMING THE MEDICARE PART B "BUY AND BILL" PROCESS TO ENCOURAGE BIOSIMILAR USE

RECOMMENDATION:

The Substitute Resolution 033 be <u>adopted in lieu of Resolution 033.</u>

RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services (CMS) to:
(a) identify groups of Physician-Administered Drugs (PADs), comprised of both branded/patented drugs and all generics and biosimilar versions (based on FDA approvals), to be reimbursed at the same rate to incentivize selection of less expensive generics and biosimilars for patients; and
(b) decide the rate at which a group of PADs will be reimbursed such that physicians are compensated appropriately for acquisition, inventory, carrying, and administration costs, including but not limited to using the average or median ASP for all PADs in a group, creating fixed fees to be used for all PADs in a group when multiple exist, and indexing spending increases for a group of PADs to the rate of inflation.

RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services (CMS) to identify groups of Physician-Administered Drug biosimilars (based on FDA approvals) to be reimbursed at the same rate to incentivize selection of less expensive biosimilars for patients; and be it further

RESOLVED, That our AMA encourages the Centers for Medicare and Medicaid Services to decide the rate at which a group of biosimilars will be reimbursed such that physicians are compensated appropriately for acquisition, inventory, carrying, and administration costs, including but not limited to using the average or median ASP for all biosimilars in a group, created fixed fees to be used for all biosimilars in a group when multiple exist, and indexing spending increases for a group of biosimilars to the rate of inflation.

VRC testimony was mixed. Your Reference Committee agrees with testimony from the authors to clarify the language by merging the second Resolve into the first. We are open to an external study if this is passed by the MSS Assembly and forwarded to the AMA House of Delegates. The Reference Committee recommends adoption of the substitute resolution in lieu of Resolution 033.

(51) RESOLUTION 055 - INCORPORATING HOLOCAUST EDUCATION IN MEDICAL SCHOOLS ON INTERNATIONAL REMEMBRANCE DAY

RECOMMENDATION:

Substitute Resolution 055 be <u>adopted in lieu of Resolution 055</u>.

RESOLVED, Our AMA host an annual event in support of International Holocaust Remembrance Day (January 27) to provide education to medical trainees about the role of physicians in the Holocaust.

RESOLVED, Our AMA encourage allopathic and osteopathic medical schools to provide education about physician roles in the Holocaust in an annual event to be held on International Holocaust Remembrance Day (January 27) or a time near this date; and be it further

RESOLVED, Our AMA encourage the LCME to continue to survey medical schools on a regular basis (e.g., every 5 years) on the manner in which education is presented on the roles of physicians in the Holocaust, thus creating an opportunity to track progress and share creative strategies and successes; and be it further

RESOLVED, Our AMA consider bringing the issue of education regarding physician roles in the Holocaust to the World Medical Association; and be it further

RESOLVED, Our AMA supports investigation, evaluation and dissemination activities to enhance student and practitioner understanding of and reflection on the complex legacies of physician involvement in the Holocaust.

VRC testimony was supportive of amendments due to concerns of feasibility. The Reference Committee agrees with testimony to address the lack of feasibility by placing

the onus on the AMA to organize education around this issue. Therefore, we recommend adoption of a substitute resolution in lieu of Resolution 055.

(52) IOP/ETF REPORT - INTERNAL OPERATING PROCEDURES/ELECTION TASK FORCE REPORT

RECOMMENDATION:

The following Substitute Recommendations be <u>adopted in lieu of IOP/ETF Report</u>.

1. That our AMA-MSS Governing Council disband the 2021-2022 IOP/Election Task Force.

2. That our AMA-MSS Governing Council establish a task force entitled "2022 IOP Task Force" with the following parameters:
(i) The task force shall be composed of at least one (1) and no more than two (2) members of each AMA-MSS region.
(ii) Members of the 2021-2022 IOP/Election Task Force shall be given first priority to serve on the 2022 IOP Task Force.
(iii) Remaining regional seats on the 2022 IOP Task Force shall be filled through recommendation by Region Chairs and decision by the AMA-MSS Governing Council.
(iv) Members of the 2022 IOP Task Force shall not be eligible to run for a nationally-elected position within the AMA-MSS for the duration of their tenure.
(v) The task force shall be created by July 2022, and it shall exist for the duration required to complete the requested study.

3. That our AMA-MSS charge the 2022 IOP Task Force with studying the changes to the MSS Internal Operating Procedures (IOP) proposed by the 2021-2022 IOP/Election Task Force through a report due by the Interim 2022 MSS Assembly meeting, or its equivalent.

4. That the 2022 IOP Task Force conduct regular and frequent open forums between the Annual 2022 and Interim 2022 meetings, in partnership with regional and local leadership, that equitably allow for a diversity of AMA-MSS members to provide feedback on the 2021-2022 IOP/Election Task Force Report.

5. That the 2022 IOP Task Force includes a section in their report that details the process of conducting these open forums; the diversity of participation by AMA-MSS members, regions, and leadership; the feedback received; and their responses to the feedback.

Several students on the VRC commended the efforts of this task force in constructing such a thoughtful and comprehensive report, and your Reference Committee would like to echo their sentiments. Multiple concerns were raised on VRC from a range of individuals, committees, and leadership. To allow for the incorporation of this feedback and to allow

additional parties to be involved in this process, we recommend the substitute recommendations.

Due to the complex and interdependent process that is IOP revision, we believe it is important to move forward with a single unified proposal incorporating carefully considered feedback from all stakeholders with all changes prior to review by OGC and eventual adoption.

Our substitute recommendations address concerns enumerated on the VRC. Due to multiple concerns that previous task force members would not have the option to run for elections, we have come to the recommendation of creating a new task force and allowing prior members to continue on if they wish.

We understand that there have also been concerns that the MSS members have not been able to have adequate time nor knowledge of this report. To address this concern, we have recommended that there should be more involvement on behalf of regional leaders and local leaders in the process of getting feedback on the proposed changes to our IOPs. We offer these substitute recommendations with the intent that a structured comment period will allow for the development of a robust, fully-reviewed, and unified proposal that can be dispatched in an efficient and organized manner at our I-22 meeting.

Your Reference Committee recommends adoption of the substitute recommendations in lieu of the IOP/ETF Report.

(53) COLRP COLA REPORT A - PROMOTION AND SUPPORT OF PHYSICIAN, STUDENT, AND PATIENT PARTICIPATION IN GOVERNMENT
RESOLUTION 002 - SUPPORTING VOTING FOR HOSPITALIZED PATIENTS

RECOMMENDATION A:

COLRP COLA Report A be <u>amended by addition of a new Recommendation</u> to read as follows:

<u>That our AMA-MSS study trends in voting participation of physicians and trainees in order to make recommendations on how to engage medical professionals in the voting process, with report back by the I-22 AMA-MSS meeting (or its equivalent).</u>

RECOMMENDATION B:

COLRP COLA Report A be <u>adopted as amended in lieu of Resolution 002</u>.

COLRP COLA Report A
Your Committee on Long Range Planning and Committee on Legislation and Advocacy recommends that the following recommendations be adopted:
RESOLVED, That our AMA recognize voting as a dimension of public health; and be it further

RESOLVED, That our AMA formally support non-partisan voter registration in healthcare

settings, including efforts to identify and aid patients who require additional assistance to vote in national elections.

Your Committee on Long Range Planning and Committee on Legislation and Advocacy recommends that the following recommendations be not adopted and the remainder of this report be filed:

RESOLVED, That our AMA promote civic engagement among its members through actions, including but not limited to:

a) Partnering with Civic Health Month or another stakeholder at the crossroads of civic engagement and health

b) Disseminating nonpartisan election information for national elections to its members

c) Encourage its members to identify patients who may require additional assistance to vote in national elections; and be it further

RESOLVED, That our AMA encourage medical schools and entities employing healthcare professionals to target and facilitate 100% eligible employee voter registration and participation.

Resolution 002

RESOLVED, That our AMA amend policy H-440.805, "Support for Safe and Equitable Access to Voting" by insertion as follows:

H-440.805 Support for Safe and Equitable Access to Voting

Our AMA will support measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improve access to drop off locations for mail-in or early ballots; (g) use of a PO Box for voter registration; (h) improving accessible voting measures for hospitalized patients.

Our AMA will oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.

VRC testimony was supportive of COLRP COLA Report A and Resolution 002. MSS recently supported a resolution that will be brought to the AMA Annual Meeting of the House of Delegates to address what the authors are attempting to amend in Resolution 002. We recommend further study of the third and fourth Resolve clauses of COLRP COLA Report A. Thus, Your Reference Committee recommends adopting the COLRP COLA Report A as amended in lieu of Resolution 002.

RECOMMENDED FOR REFERRAL

(54) RESOLUTION 021 - EXPANDING AND RECLASSIFYING EMERGENCY MEDICAL SERVICES

RECOMMENDATION:

Resolution 021 be referred.

RESOLVED, Our AMA recognizes the impact of health care services provisioned by emergency medical service (EMS) providers on patient health outcomes; and be it further

RESOLVED, Our AMA supports state and federal classification and establishment of EMS as an essential service; and be it further

RESOLVED, That our AMA amend H-130.970 by addition:

Access to Emergency Services H-130.970
(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility or involving out-of-hospital treatment and transportation after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

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

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

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

(E) All health payers should be required to cover emergency services provided by physicians, and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further

examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

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

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

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

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

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care.

VRC testimony was supportive. The Reference Committee agrees with the spirit of this resolution. We also agree with testimony from the American College of Emergency Physicians (ACEP) that this is a complicated issue and would benefit from clarification of the second and third resolved clauses. We recommend Resolution 021 be referred.

(55) RESOLUTION 036 - FORTIFYING FAT-SOLUBLE FOODS WITH VITAMIN D

RECOMMENDATION:

Resolution 036 be <u>referred.</u>

RESOLVED, That our AMA encourages relevant federal agencies such as the FDA to adopt a standard of identity encompassing the addition of vitamin D to a variety of fat-soluble food items.

VRC testimony was supportive of the spirit to address the timely issue of Vitamin D deficiency. There was testimony to share concern about the feasibility of the ask. Your Reference Committee found that the whereas clauses lack sufficient evidence and the

ask of the resolve needs more specificity. We recommend referral of Resolution 036 to a committee with subject-matter expertise to consider additional evidence and explore what actions the FDA and USDA can take.

(56) RESOLUTION 042 - CONDEMNATION OF NON-THERAPEUTIC STERILIZATION FOR CONTRACEPTION OF WOMEN WITH DISABILITIES WITHOUT INFORMED PATIENT CONSENT

RECOMMENDATION:

Resolution 042 be referred.

RESOLVED, That our AMA advocate for and actively support national legislation that bans guardians from attaining a sterilization deemed non-therapeutic for their disabled patient in their care.

VRC testimony was supportive of referral. Your Reference Committee agrees with testimony that referral to study would help expand the ask and include person first language. The resolution as written is not supported by sufficient evidence, and can be expanded to encompass a broader scope for harm of forced sterilization. Of note, The American College of Obstetricians and Gynecologists (ACOG) commented that this topic is currently being looked into, although support for this as of now may be premature. We recommend this resolution be referred.

(57) RESOLUTION 049 - ADVOCATING FOR THE INCLUSION OF WEIGHT BIAS TRAINING FOR MEDICAL STUDENTS

RECOMMENDATION:

Resolution 049 be referred.

RESOLVED, Our AMA recognizes the negative effects of weight bias on patients and physicians and be committed to addressing it alongside other forms of bias; further be it

RESOLVED, Our AMA supports the inclusion of weight bias education for medical students as part of the anti-bias training curricula, while working with relevant stakeholders; further be it

RESOLVED, To support weight-inclusive health policy, our AMA amends Policy H440.821, “Person-First Language for Obesity”

Person-First Language for Obesity to Decrease Weight Bias, H-440.821
Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; (3) encourages healthcare providers to use evidence-based interventions when discussing health and disease with patients; and (43) will educate health care providers on the importance of person-first language for

treating patients with obesity, including the harmful effects of weight bias and other similar assumptions; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the resolution is not well-supported by evidence. We believe the authors have managed to establish that weight bias in providers is an issue, but more data is needed to support which solution(s) will be best to address this. The Reference Committee recommends Resolution 049 be referred to study.

(58) GC REPORT B – RESOLUTION TASK FORCE UPDATE 2022

RECOMMENDATION:

Recommendations from GC Report B be referred.

Your AMA-MSS GC recommends the following recommendations be adopted and the remainder of the report be filed:

RESOLVED, That the original recommendations of the 2018 AMA-MSS Resolutions Task Force continue to be upheld, implemented, or supplemented as follows:

630.075MSS ~~Pilot Implementation of the 2018 Resolution Task Force Recommendations~~Ongoing implementation of MSS resolution process reforms:
MSS will:
1. Invest in further education efforts of the resolution process by: a) training RD/ADs to provide better guidance on the various mechanisms available for advocacy through the AMA and MSS; and
b) ~~Making a~~ Maintaining videos and "cheat sheets" explaining the basics of Parliamentary Procedure and the most common mistakes made;
2. Elevate the stature of non-resolution avenues for advocacy by: a) clarifying what makes a successful GC Action Item, publicizing GC Action Item Requests widely, and increasing the prestige of these proposals; b) creating a new, informational category of business for the Assembly, which would be presented by authors in a separate programming session at the meeting. The process for accepting and reviewing submissions for this category of business and executing this session will be directed by MSS Standing Committees and the MSS GC Vice Chair; c) Providing a formal document to its members as proof of significant, non-resolution-related work, which they can provide as support for a conference funding and time-off request. Examples of significant, non-resolution-related work include serving as a Delegate or on a Committee;
3. Encourage mentorship between its members and throughout the AMA by: a) Creating a voluntary indicator on the Open Forum and during the resolution draft phase that shows if the originator is a first-time author. This visibility would allow more experienced writers to help new authors and mentor them through the process; and b) Requiring that ~~all~~ external resolutions ~~authors to contact~~ be sent to the relevant specialty society prior to submission to the MSS Assembly to receive input for consideration by the Reference Committee;

4. Improve transparency of resolution feedback among all actors throughout the resolution process by: a) tasking the Government Relations Advocacy Fellow and Section Delegates with analyzing the Open Forum and resolution drafts for resolutions that the AMA Federal Advocacy Office would be interested in reviewing. These roles are noted by the MSS GC to have an appropriate level of understanding of what would be suitable for review by the Federal Advocacy Office; b) Broadening the functional scope of the House of Delegates Coordinating Committee (HCC) so HCC members can contact Region leaders to improve resolutions that would otherwise likely be reaffirmed; c) Requiring primary reviewers' ~~to send~~ feedback summary emails to be sent to the primary author's Region Chair and Region Delegation Chair in order to allow Regions to incorporate draft feedback into their Region authorship voting if they choose to; d) Requesting that HCC post a summary of their comments from the draft review process to the VRC; e) Requesting that RD/ADs provide meaningful testimony on the VRC for resolutions they reviewed, especially in cases where important recommendations from feedback provided to authors were not considered;
5. Streamline existing procedures in the resolution process by: a) Coordinating Region resolution authorship/support through a central AMA email process so more medical school sections can be reached; b) Giving HCC responsibility to review all submissions and place items on a Reaffirmation Consent Calendar. Items on the Reaffirmation Consent calendar will not receive detailed staff review except analysis from Legal Counsel; c) Adjusting resolution deadlines to allow more time for review between the final submission and the VRC;
6. Change its scoring rubric to: a) Reaffirm its existing rubric categories of authorship, clarity, research quality, scope, feasibility, novelty, addressing the MSS Policy Objectives and AMA Strategic Focus Areas, thoughtful response to feedback, and scoring on a quantitative scale; b) For external resolutions, increase the scoring weight of addressing the MSS Policy Objectives over that of addressing the AMA Strategic Focus Areas, as a way to promote Section objectives; c) Include scoring of the fiscal note as a consideration for feasibility, instead of as a separate rubric category;
7. Reaffirm its existing process of creating the Assembly's Order of Business according to quantitative resolution scores;
8. Create and further opportunities for high-quality discussion in the Assembly by: a) The MSS Reference Committee noting in its rationale whether resolutions are suitable for a GC Action Item. GC Action items may be submitted by the originating author or by individual members of the Section; ~~and~~
9. Improve continuity of its advocacy efforts from meeting to meeting by: a) Requiring authors of external resolutions to sign a virtual acknowledgement agreeing to help the Section Delegates and Regional Delegates in bringing their resolution to the AMA HOD if their resolution is passed by the Assembly; b) Tracking the outcome of MSS-initiated external resolutions that have had influence or impact. An example of influence or impact is action taken or statements made by the AMA Board of Trustees. These outcomes can be recorded by the MSS GC, HOD Reference Committee Team Leads, and Regional Delegation Chairs and shared with the Section membership; and c) Giving the MSS GC responsibility for conducting an annual survey that sets MSS Policy Objectives for the given year;
10. Continue creating a process by which Standing Committee reports undergo review in a similar manner to the resolution review process

11. Continue a trial period of virtual extractions from the Reference Committee Report for future in-person meetings and report on the satisfaction and outcomes of this process to the Section;
12. Work with relevant stakeholders including relevant AMA-MSS Standing Committees, AMA liaisons, partner medical student organizations, the AMA Center for Health Equity, and others to continue building more permanent processes by which our AMA-MSS can better evaluate its resolutions for their impact on equity; and
13. Continue investigating methods to improve institutional memory, including potentially a system of guides required from AMA-MSS original authors whenever their resolution is adopted to be sent to the AMA HOD.
; and be it further

RESOLVED, That these changes, and the AMA-MSS resolutions process as a whole, will be re-evaluated in an AMA-MSS Governing Council report to be presented 5 years after the adoption of these recommendations.

VRC testimony was not supportive of the report recommendations as written and offered amendments and/or supported for referral. The Reference Committee agrees with VRC testimony that the trial period of virtual extractions in subpoint 11 is concerning.

We believe that contributions from other MSS stakeholders is important to ensure MSS Report B includes input from MSS Caucus, Regions, and general MSS members.

Your Reference Committee shares concerns with VRC testimony on subpoint 12 to evaluate resolutions based on their equity impact. The MSS has many policy objectives that should be taken into consideration in addition to equity.

We believe that allowing extractions to take place both virtually and in person, soliciting input from MSS members, and integrating MSS policy objectives into the recommendations would strengthen the report. We encourage referral of this report to a committee with subject matter expertise. Your Reference Committee recommends referral of GC Report B.

(59) MIC CGPH REPORT A - MENTAL HEALTH REFORM IN PRISONS

RECOMMENDATION:

Recommendations from MIC CGPH Report A be referred.

Your Minority Issues Committee and Committee on Global and Public Health recommend that the following Resolved clauses be adopted in lieu of the proposed Resolved clause(s) and the remainder of this report be filed:

RESOLVED That our AMA supports conducting mental health screening of all individuals entering or reentering the prison system in order to improve diversion practices as well as treatment access

RESOLVED our AMA advocates for the continuation of mental health care for individuals post-incarceration and the development or exacerbation of mental health illness/needs by screening individuals upon release

RESOLVED our AMA supports research for other ways to best help individuals with mental health needs (universalized method and implementation of effective screening)

VRC testimony was limited. Your Reference Committee agrees with testimony that the language in the second resolved clause can be clarified and the third resolved clause is not supported by the report. We recommend referral of the recommendations of MIC CGPH Report A.

RECOMMENDED FOR NOT ADOPTION

(60) RESOLUTION 019 - IMPROVING SAFETY OF PLANNED HOME BIRTHS THROUGH MIDWIFERY LICENSING AND REGULATION

RECOMMENDATION:

Resolution 019 not be adopted.

RESOLVED, Our AMA will encourage integration of community-based midwifery practice into the healthcare system to promote maternal and neonatal health and health equity by amending policy D-35.989, Midwifery Scope of Practice and Licensure, to read as follows:

Midwifery Scope of Practice and Licensure, D-35.989:
Our AMA will:

(1) only advocate in legislative and regulatory arenas for the licensing of midwives who are certified by the American College of Nurse-Midwives (or its predecessor organizations) or whose education meets the International Confederation of Midwives Global Standards for Midwifery Education;
(2) support state legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of state nursing and/or medical boards;
(3) continue to monitor state legislative activities regarding the licensure and scope of practice of midwives; and
(4) work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives.

RESOLVED, Our AMA will encourage informed choice in birth setting and support legislation to improve safety of planned home birth by amending policy H-245.971, Home Deliveries, to read as follows:

Planned Home Births ~~Deliveries~~ H-245.971

Our AMA: (1) supports ~~the recent American College of Obstetricians and Gynecologists (ACOG) statement that "the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers"~~ informing pregnant people inquiring about planned home birth of its risks and benefits based on recent evidence; ~~and~~ (2) supports state legislation that helps ensure safe deliveries and healthy babies by acknowledging that the safest setting for labor, delivery and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the AAP and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers; and (3) supports state legislation that

helps achieve favorable home birth outcomes by facilitating the appropriate selection of candidates for home birth; increasing the availability of a certified nurse–midwife, certified midwife or midwife whose education and licensure meet International Confederation of Midwives' Global Standards for Midwifery Education; and establishing protocols for ready access to consultation and safe and timely transport to nearby hospitals.

VRC testimony was mixed. Your Reference Committee agrees with testimony from The American College of Obstetricians and Gynecologists (ACOG) that the resolution as written would create an unnecessary scope battle. Additionally, we agree with testimony that the whereas clauses do not support the link between lack of licensing and poorer outcomes. Therefore, the Reference Committee recommends Resolution 019 not be adopted.

(61) RESOLUTION 025 - MEDICAL HISTORIES OF GAMETE DONORS AND DONOR CONCEIVED PEOPLE

RECOMMENDATION:

Resolution 025 not be adopted.

RESOLVED, That our AMA recognize that physicians have an ethical duty to verify the accuracy of medical histories provided by gamete donors with medical records at the time of gamete donation; and it be further

RESOLVED, That our AMA encourage physicians to obtain regular and pertinent updates to the medical histories provided by gamete donors and donor conceived persons in their care, and communicate these updates to recipient families or the sperm or oocyte clinics from where the gametes were obtained, so that pertinent medical updates may be shared with the gamete donor and all recipient families that used the same donor.

VRC testimony was limited and opposed the resolution as written. Your Reference Committee agrees with concerns that this resolution is adding an unintended liability burden to physicians. We recommend Resolution 025 not be adopted.

(62) RESOLUTION 032 - SUPPORT FOR MANDATED NURSE-PATIENT RATIOS

RECOMMENDATION:

Resolution 032 not be adopted.

RESOLVED; That our AMA amend policy H-360.986 to read as follows

Professional Nurse Staffing in Hospitals H-360.986
The AMA: (1) encourages medical and nursing staffs in each facility to closely monitor the quality of medical care to help guide hospital administrations toward the best use of resources for patients;
(2) encourages medical and nursing staffs to work together to develop and implement in-service education programs and promote compliance with established or pending

guidelines for unlicensed assistive personnel and technicians that will help assure the highest and safest standards of patient care;
(3) encourages medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials, and/or title of the physicians, nurses, allied health personnel, and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care;
(4) encourages medical and nursing staffs to develop, promote, and implement educational guidelines for the training of all unlicensed personnel working in critical care units, according to the needs at each facility; and
(5) encourages medical and nursing staffs to work with hospital administrations to assure that patient care and safety are not compromised when a hospital's environment and staffing are restructured.
(6) supports the development of mandated minimum nurse-patient ratios based on acuity level and patient safety.

VRC testimony was mixed. The Reference Committee agrees with testimony that the specifics of practice of other healthcare providers is outside the AMA's scope. We recommend Resolution 032 not be adopted.

(63) RESOLUTION 034 - PHARMACY ACCESS TO HUMAN IMMUNODEFICIENCY VIRUS (HIV) PRE-EXPOSURE PROPHYLAXIS (PREP) & POST-EXPOSURE PROPHYLAXIS (PEP)

RECOMMENDATION:

Resolution 034 not be adopted.

RESOLVED, That our AMA support federal and state efforts to make HIV PrEP prescribable by pharmacists with evidence of a recent negative HIV test in accordance with best practice guidelines, including efforts to make rapid HIV tests available and affordable to patients requesting PrEP; and be it further

RESOLVED, That our AMA support federal and state efforts to make HIV Post-Exposure Prophylaxis (PEP) prescribable by pharmacists.

VRC testimony was mixed, with support for the spirit of the resolution but concerns around scope. Your Reference Committee agreed with testimony from the Gay & Lesbian Medical Association (GLMA) that the monitoring and intervention required for patients using PrEP or PEP could fall out of scope for pharmacists. The prescription of PrEP or PEP is not only contingent upon HIV status, but also a myriad of other factors that should involve a physician. We recommend Resolution 034 not be adopted.

(64) RESOLUTION 038 - SUPPORTING RESEARCH INTO ARTIFICIAL WOMB TECHNOLOGIES

RECOMMENDATION:

Resolution 038 not be adopted.

RESOLVED, That our AMA supports comprehensive research into artificial womb technologies which seeks to understand its ethical, societal, and legal consequences.

VRC testimony was opposed to Resolution 038. Your Reference Committee agrees with testimony that the resolved clause is not supported by research. Additionally, we believe this ask to be outside of the scope of the AMA and note that relevant societies such as American College of Obstetricians and Gynecologists (ACOG) have no stance on this issue. The Reference Committee recommends Resolution 038 not be adopted.

(65) RESOLUTION 043 - THE IMPACTS OF COVID-19 AND TELEMEDICINE ON NATIONAL OPIOID PRESCRIPTION PATTERNS

RECOMMENDATION:

Resolution 043 not be adopted.

RESOLVED, That our AMA study how the patterns of opioid prescriptions and overdoses have changed on a national scale since the relaxation of the Ryan Haight Act's requirement of in-person visits prior to prescribing opioids; and be it further

RESOLVED, That our AMA study the factors that influence physician comfort with prescribing controlled substances such as buprenorphine for medication assisted treatment (MAT) via telemedicine on a national scale.

VRC testimony was mixed. Your Reference Committee agrees with testimony that the resolution as written does not align with current AMA priorities. Notably, we are concerned that this resolution will unintentionally negatively impact the use of medications for opioid use disorder (MOUD) and could create a barrier to medication access. We deliberated multiple outcomes and ultimately recommend that this resolution not be adopted.

(66) RESOLUTION 054 - DECREASING SCREEN TIME IN SCHOOL AND FOR SCHOOL-RELATED ACTIVITIES

RECOMMENDATION:

Resolution 054 not be adopted.

RESOLVED; that our AMA ask teachers, schools, and other educational entities to take into account how much screen time children and adolescents are exposed to at school when developing curricula and limit educational screen time at school and for school-related activities and be it further

RESOLVED; that our AMA supports research efforts evaluating how much screen time is appropriate for adolescents and children over the age of 6 in schools.

VRC testimony was mixed. Your Reference Committee agrees with testimony from the American Academy of Pediatrics (AAP) that the AMA is not the best organization to accomplish the asks of this resolution. We recommend that Resolution 054 not be adopted.

(67) COLA MIC REPORT A - IMG EXEMPTIONS FROM IMMIGRATION CAPS ON IMG-SPECIFIC IMMIGRATION CATEGORY FOR GREEN CARDS AND VISAS

RECOMMENDATION:

The Recommendations of COLA MIC Report A <u>not be adopted.</u>

Your Committee on Legislation and Advocacy and Minority Issues Committee recommend that the following recommendation be adopted, and the remainder of this report filed:

RESOLVED, Our AMA-MSS support the implementation of a healthcare worker VISA category specifically for IMGs and IMSs, which could ease post-VISA foreign residence requirements and allow for appropriate VISA travel guidelines to continue patient care; and be it further

RESOLVED, Our AMA-MSS support the creation of broad and accessible IMG-specific bridge programs between education-based and employment-based VISAs to increase retention of J-1 VISA recipients who complete medical training in the US; and be it further

RESOLVED, Our AMA-MSS support the implementation of profession-specific or education level exemptions for residents and physicians from the annual caps for EB-1,2 green cards and H-1B temporary work VISAs in order to decrease barriers of non-citizen International Medical Graduates from practicing in the US.

VRC testimony was mixed. Your Reference Committee agrees with testimony from the International Medical Graduates Section (IMGS) that this report does not accurately convey immigration processes. We support the spirit of this report, but we believe that this topic falls outside of the MSS's scope. Your Reference Committee recommends that COLA MIC Report A not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(68) RESOLUTION 023 - INCORPORATION OF EVIDENCE-BASED VACCINE COMMUNICATION STRATEGIES IN MEDICAL SCHOOL CURRICULUM

RECOMMENDATION:

Policy H-440.877, D-440.921, H-440.977, and H-440.849 be reaffirmed in lieu of Resolution 023.

RESOLVED, That our AMA works with relevant stakeholders to support the adoption of evidence-based strategies for vaccination advocacy and communication into medical school curricula.

VRC testimony was mixed. Your Reference Committee agrees with testimony that this resolution is covered under existing policies. We recommend the authors submit a Medical Student Section Action Item (MSSAI) to work with stakeholders to enact curricular change as an extension of existing policies around the distribution of vaccines. The Reference Committee recommends reaffirmation of existing policies in lieu of Resolution 023.

H-440.877 Distribution and Administration of Vaccines
1. It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record.
2. All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP recommendations must be ensured timely access to adequate vaccine supply.
3. Physicians and other qualified health care providers should: (a) incorporate immunization needs into clinical encounters, as appropriate; (b) strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines; (c) either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations and professional guidelines and consistent with state laws; (d) ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists; and (e) maintain professional competencies in immunization practices, as appropriate.
4. All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law.

5. Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician.
6. Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers.
7. Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community.
8. Our AMA encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.

D-440.921 An Urgent Initiative to Support COVID-19 Vaccination and Information Programs
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 (6) supporting the public purchase and cost-free distribution and administration of COVID-19 booster vaccine doses.

H-440.977 Hepatitis B Vaccine
The AMA urges the appropriate use of hepatitis B vaccine and the dissemination of professional educational materials to increase the use of the hepatitis B vaccine by physicians whose patients are in high risk groups, including physicians in training and other medical personnel who come into contact with blood and blood products, tissues, secretions and excretions demonstrated to be potential reservoirs of hepatitis B virus.

H-440.849 Adult Immunization

Our AMA (1) supports the development of a strong adult and adolescent immunization program in the United States; (2) encourages physicians and other health and medical workers (in practice and in training) to set positive examples by assuring that they are completely immunized; (3) urges physicians to advocate immunization with all adult patients to whom they provide care, to provide indicated vaccines to ambulatory as well as hospitalized patients, and to maintain complete immunization records, providing copies to patients as necessary; (4) encourages the National Influenza Vaccine Summit to examine mechanisms to ensure that patient immunizations get communicated to their personal physician; (5) promotes use of available public and professional educational materials to increase use of vaccines and toxoids by physicians and to increase requests for and acceptance of these antigens by adults for whom they are indicated; and (6) encourages third party payers to provide coverage for adult immunizations.

(69) RESOLUTION 028 - TREATMENT PROGRAMS FOR ADOLESCENTS WITH SUBSTANCE USE DISORDER

RECOMMENDATION:

Policy H-95.975 be <u>reaffirmed in lieu of</u> Resolution 028.

RESOLVED, the AMA recognizes targeted treatment options designed specifically for adolescents with a substance use disorder are necessary to care for the special needs of this patient population; and be it further

RESOLVED, the AMA supports the need for adequate federal funding for research into developmentally and age-appropriate treatment options for adolescents with a substance use disorders.

VRC testimony was mixed. The House Coordination Committee (HCC) slated Resolution 028 for reaffirmation on their consent calendar. Your Reference Committee agrees that existing Policy H-95.975 covers all people, and that adolescents do not need to be separately specified. We therefore recommend reaffirmation of Policy H-95.975 in lieu of Resolution 028.

H-95.975 - Substance Use Disorders as a Public Health Hazard
Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;
(2) declares substance use disorders are a public health priority;
(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;
(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and
(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter

drugs with the intent of circumventing laws prohibiting possession or use of such substances.

(70) RESOLUTION 039 – MEDICAL REVERSAL

RECOMMENDATION:

Policy H-460.909 be <u>reaffirmed in lieu of</u> Resolution 039.

RESOLVED, That our AMA recognizes medical reversal and lower standards for approval of a treatment/procedure guideline as a contributing factor to that treatment/procedure guideline eventually becoming medically reversed; and be it further

RESOLVED, That our AMA oppose the adoption of treatment/procedure guidelines on lower standards for approval for the purpose of reducing the frequency of medical reversals; and be it further

RESOLVED, That our AMA supports research efforts to identify and reduce the frequency of medical reversals.

VRC testimony was split between opposition and reaffirmation. The House Coordination Committee (HCC) slated the second resolve clause for reaffirmation. Your Reference Committee agrees with testimony that Resolution 039 is covered by existing AMA policy. We recommend Policy H-460.909 be reaffirmed in lieu of Resolution 039.

Comparative Effectiveness Research H-460.909
The following Principles for Creating a Centralized Comparative Effectiveness Research Entity are the official policy of our AMA:
PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS RESEARCH ENTITY:
A. Value. Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the US health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.
B. Independence. A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.
C. Stable Funding. The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.
D. Rigorous Scientifically Sound Methodology. CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.
E. Transparent Process. The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and

disseminating findings must be transparent and provide physicians and researchers a central and significant role.

F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.

G. Conflicts of Interest Disclosed and Minimized. All conflicts of interest must be disclosed and safeguards developed to minimize actual, potential and perceived conflicts of interest to ensure that stakeholders with such conflicts of interest do not undermine the integrity and legitimacy of the research findings and conclusions.

H. Scope of Research. CER should include long term and short term assessments of diagnostic and treatment modalities for a given disease or condition in a defined population of patients. Diagnostic and treatment modalities should include drugs, biologics, imaging and laboratory tests, medical devices, health services, or combinations. It should not be limited to new treatments. In addition, the findings should be re-evaluated periodically, as needed, based on the development of new alternatives and the emergence of new safety or efficacy data. The priority areas of CER should be on high volume, high cost diagnosis, treatment, and health services for which there is significant variation in practice. Research priorities and methodology should factor in any systematic variations in disease prevalence or response across groups by race, ethnicity, gender, age, geography, and economic status.

I. Dissemination of Research. The CER entity must work with health care professionals and health care professional organizations to effectively disseminate the results in a timely manner by significantly expanding dissemination capacity and intensifying efforts to communicate to physicians utilizing a variety of strategies and methods. All research findings must be readily and easily accessible to physicians as well as the public without limits imposed by the federally supported CER entity. The highest priority should be placed on targeting health care professionals and their organizations to ensure rapid dissemination to those who develop diagnostic and treatment plans.

J. Coverage and Payment. The CER entity must not have a role in making or recommending coverage or payment decisions for payers.

K. Patient Variation and Physician Discretion. Physician discretion in the treatment of individual patients remains central to the practice of medicine. CER evidence cannot adequately address the wide array of patients with their unique clinical characteristics, co-morbidities and certain genetic characteristics. In addition, patient autonomy and choice may play a significant role in both CER findings and diagnostic/treatment planning in the clinical setting. As a result, sufficient information should be made available on the limitations and exceptions of CER studies so that physicians who are making individualized treatment plans will be able to differentiate patients to whom the study findings apply from those for whom the study is not representative.

(71) RESOLUTION 041 - ENCOURAGING INCREASED DERMATOLOGIC TRAINING IN PRIMARY CARE SETTINGS TO REDUCE RACIAL DISPARITIES IN MELANOMA OUTCOMES

RECOMMENDATION:

Policy H-295.853 be reaffirmed in lieu of Resolution 041.

RESOLVED, That our AMA amend current policy **H-55.972**, **"**Early Detection and Prevention of Skin Cancer**"** by addition to read as follows:
Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination, (2) supports increased training for primary care physicians regarding common patient misconceptions and best practices to counsel patients on skin self-examinations and troublesome skin findings for patients of color; (3) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (4) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color; and (5) supports incorporation of training modules and diagnostic technology, including but not limited to dermoscopy, to improve dermatologic understanding in patients of color among primary care physicians.

VRC testimony was mixed, with support for reaffirmation, adoption with amendments, and opposition. Your Reference Committee agrees with the House Coordination Committee (HCC) that this resolution falls under existing policy. We recommend reaffirmation of existing policy H-295.853 in lieu of this resolution.

H-295.853 Representation of Dermatological Pathologies in Varying Skin Tones
Our AMA encourages comprehensive, inclusive and equitable representation of a diverse range of skin tones in all dermatologic and other relevant medical educational resources for medical students, physicians, non-physician healthcare providers and patients.

(72) RESOLUTION 044 - INCREASED DOULA ACCESS TO SUPPORT PREGNANT AND BIRTHING PEOPLE

RECOMMENDATION:

Policy H-185.917 be reaffirmed in lieu of Resolution 044.

RESOLVED, Our AMA supports initiatives to improve the accessibility of support personnel, such as a professional doula, for pregnant and birthing people, and the

availability of information about the benefits of doula services for patients and physicians.

VRC testimony was mixed. The Reference Committee agrees with testimony that defining the doula profession, and therefore this resolution, falls outside of the AMA's scope. The Reference Committee also agrees that the evidence is inconclusive for this as a solution to health disparities among pregnant and birthing people. The House Coordination Committee (HCC) added this resolution to their reaffirmation consent calendar. We would recommend a stance of not adopt given the issue of scope, but we recommend reaffirmation of this resolution because it has been listed as reaffirmation by HCC.

H-185.917 Reducing Inequities and Improving Access to Insurance for Maternal Health Care

1. Our AMA acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be: (a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories), (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and (c) lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.
6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.

7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.
8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.
9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.
11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.

(73) RESOLUTION 045 - REFORMING THE RESIDENCY MATCH SYSTEM

RECOMMENDATION:

Policy D-310.977 be <u>reaffirmed in lieu of</u> Resolution 045.

RESOLVED, That our AMA study the impact of residency application and interview caps; and be it further

RESOLVED, That our AMA support disclosure of all application filters (including but not limited to Step 1 or Step 2CK scores, MD vs DO degree, or IMG status) used by residency programs to facilitate applicant decision making and decrease overapplication; and be it further

RESOLVED, That our AMA support the shortening of the residency interview season to only October, November, and December, or a similar three-month period; and be it further

RESOLVED, That our AMA support the adoption by each specialty of a standardized interview invitation date accompanied by a standardized interview acceptance period, with subsequent rolling interview invitations permitted for unfilled interview slots.

VRC testimony was supportive of the spirit of the resolution, but with concerns around unintended consequences and equity. The Young Physicians Section (YPS) expresses concerns around the implications of disclosing application filters in the setting of a holistic application process. The AMA International Medical Graduates Section (IMGS) expresses concerns around shortening the interview season given that international medical graduates historically may require a longer interview season. The House

Coordination Committee (HCC) slated this resolution as a reaffirmation of existing Policy D-310.977. The AMA Council on Medical Education (CME) will bring a report forward at the 2022 Interim Meeting on residency. Your Reference Committee agrees with HCC that Resolution 045 is reaffirmation and looks forward to the upcoming CME report. We recommend Policy D-310.977 be reaffirmed in lieu of Resolution 045.

National Resident Matching Program Reform D-310.977
Our AMA:
(1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;
(5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of

minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;
(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine; and
(18) encourages the AAMC, AACOM, NRMP, 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.

(74) RESOLUTION 046 – SUBSIDIZING RESEARCH INTO MOLECULAR NANOTECHNOLOGY AND MOLECULAR NANOMACHINES IN MEDICINE

RECOMMENDATION:

Policy H-480.949 and H-460.998 be <u>reaffirmed in lieu of</u> Resolution 046.

RESOLVED, That our AMA support the subsidization of research pertaining to molecular nanotechnology and molecular nanomachines in diagnostic applications, imaging applications, as an alternative form of treatment, and vehicle for therapeutic delivery.

VRC testimony was opposed to the resolution as written. Your Reference Committee agrees with testimony that points out concerns of scope and feasibility. The House Coordination Committee (HCC) did not place this resolution on the reaffirmation calendar; however, we found that existing policy covers the asks of the resolved clause. Therefore, your Reference Committee recommends reaffirmation of existing Policies H-480.949 and H-460.998 in lieu of this resolution.

H-480.949 Nanotechnology, Safety and Regulation

Our AMA: (1) recognizes the benefits and potential risks of nanotechnology; (2) supports responsible regulation of nanomaterial products and applications to protect the public's health and the environment; and (3) encourages continued study on the health and environmental effects of exposure to nanomaterials.

H-460.998 Support of Biomedical Research
Our AMA endorses and supports the following ten principles considered essential if continuing support and recognition of biomedical research vital to the delivery of quality medical care is to be a national goal:
(1) The support of biomedical research is the responsibility of both government and private resources.
(2) The National Institutes of Health must be budgeted so that they can exert effective administrative and scientific leadership in the biomedical research enterprise.
(3) An appropriate balance must be struck between support of project grants and of contracts.
(4) Federal appropriations to promote research in specifically designated disease categories should be limited and made cautiously.
(5) Funds should be specifically appropriated to train personnel in biomedical research.
(6) Grants should be awarded under the peer review system.
(7) The roles of the private sector and of government in supporting biomedical research are complementary.
(8) Although the AMA supports the principle of committed federal support of biomedical research, the Association will not necessarily endorse all specific legislative and regulatory action that affects biomedical research.
(9) To implement the objectives of section 8, the Board will establish mechanisms for continuing study, review and evaluation of all aspects of federal support of biomedical research.
(10) Our AMA will accept responsibility for informing the public on the relevance of basic and clinical research to the delivery of quality medical care.

(75) RESOLUTION 047 - SUBSIDIZING RESEARCH INTO BACTERIOPHAGE MEDICINE

RECOMMENDATION:

Policy H-440.827 be <u>reaffirmed in lieu of</u> Resolution 047.

RESOLVED, That our AMA supports increased funding to major research organizations such as the National Institutes of Health to develop bacteriophage therapeutic technologies as an alternative to the use of antibiotics.

VRC testimony was mixed. The Reference Committee agrees with testimony that AMA policy already addresses alternatives to antibiotics, including bacteriophage technology, and concerns around antibiotic resistance. The House Coordination Committee (HCC) put this resolution on their reaffirmation calendar. Your Reference Committee agrees with HCC and recommends existing policy be reaffirmed in lieu of this resolution.

H-440.827 Surveillance of Antibiotic Use and Resistance

Our AMA: (1) recognizes the importance of public health and veterinary health surveillance for antimicrobial resistance and antibiotic use; and (2) recommends that public health and veterinary health agencies be adequately funded, as outlined in the President's Council of Advisors on Science and Technology Report, to achieve the surveillance goals and objectives outlined in the National Action Plan for Combating Antibiotic Resistant Bacteria.

(76) RESOLUTION 048 - ENSURE FAIR PRACTICES BY STAFFING AGENCIES

RECOMMENDATION:

Policy D-360.998 and D-383.983 be <u>reaffirmed in lieu of</u> Resolution 048.

RESOLVED, our AMA collaborates with the AHA and AHCA/ NCAL to address the shortage of healthcare workers and increased rise in labor costs in healthcare facilities; and be it further

RESOLVED, our AMA encourages the Federal Trade Commission to investigate potential anticompetitive practices conducted by direct care staffing agencies. We use the word "women" in the whereas clauses of this resolution when referring to people.

VRC testimony was split between reaffirmation and referral. The House Coordination Committee (HCC) recommends reaffirmation of Resolution 048 due to existing AMA policy. Your Reference Committee believes that referral of this resolution would not result in an expansion of current advocacy efforts, and that existing policy already addresses healthcare labor concerns and anticompetitive practices. We recommend reaffirmation of Policy D-360.998 and D-383.983 in lieu of this resolution.

D-360.998 The Growing Nursing Shortage in the United States
Our AMA:
(1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields;
(2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients;
(3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process;
(4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;
(5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care.

D-383.983 Collective Bargaining: Antitrust Immunity

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy.

(77) RESOLUTION 050 - ACCURATELY QUANTIFYING E-CIGARETTE USAGE

RECOMMENDATION:

Policy H-495.972 be <u>reaffirmed in lieu of</u> Resolution 050.

RESOLVED, Our AMA supports research that investigates more specific measures of e-cigarette usage in relation to risk for respiratory (and other) illnesses in the context of providing counseling strategies for patients and increasing public health awareness of the long-term harms of e-cigarette use.

VRC testimony was supportive of the spirit of this resolution. However, your Reference Committee agrees with testimony that this resolution is reaffirmation of existing policy. We encourage the authors to submit a Medical Student Section Action Item (MSSAI) to ask for more specific action. The Reference Committee agrees with HCC's decision to reaffirm Policy H-495.972 in lieu of this resolution.

H-495.972 Electronic Cigarettes, Vaping, and Health
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.
2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.
3. Our AMA supports legislation and associated initiatives and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and emerging tobacco products.

(78) RESOLUTION 051 - EXPANDING ACCESS TO TELEREHABILITATION

RECOMMENDATION:

Policy be reaffirmed in lieu of Resolution 051.

RESOLVED, That our AMA urge the federal government to pass legislation that expands access to telerehabilitation services including but not limited to physical therapy, nutritional therapy, social work, clinical psychology, occupational therapy, speech-language pathology, and audiology; and be it further

RESOLVED, That our AMA urge state governments to adopt policies that cover telerehabilitation services; and be it further

RESOLVED, That our AMA-MSS support the creation of interstate health compacts for telerehabilitation services from providers including but not limited to physical therapists, occupational therapists, clinical psychologists, speech-language pathologists, and audiologists, thereby allowing for improved continuity of care and continued access to follow-up; and be it further

RESOLVED, That our AMA support the inclusion of telerehabilitation on the Physician Fee Schedule; and be it further

RESOLVED, That our AMA-MSS encourage the design and execution of studies to identify healthcare providers that benefit the most from telerehabilitation services, potentially including but not limited to physical therapists, clinical psychologists, and occupational therapists, speech-language pathologists, and audiologists; and be it further

RESOLVED, That our AMA-MSS supports advocating for the use of telerehabilitation services; and be it further

RESOLVED, That the following current policy, D-480.963, “COVID-19 Emergency and Expanded Telemedicine Regulations,” be amended to reflect inclusion of telerehabilitation services in the advocacy efforts and policymaking of the AMA and other public and private organizations:

COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963
1. Our AMA will continue to advocate for widespread adoption of telehealth services, including telerehabilitation, in the practice of medicine for physicians and physician-led teams post SARS-CoV-2
2. Our AMA will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services, including telerehabilitation, that: (a) provide equitable coverage that allows patients to access telehealth and telerehabilitation services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients
3. Our AMA will advocate for equitable access to telehealth services, including telerehabilitation, especially for at-risk and under-resources 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 physicians practices and patients
4. Our AMA supports the use of telehealth and telerehabilitation to reduce health disparities and promote access to health care. Alt. Res. 203, I-20; Reaffirmed: CMS Rep. 7, A-21; and be it further

RESOLVED, That the following current policy, D-480.965, "Reimbursement for Telehealth," be amended to reflect inclusion of telerehabilitation services in insurance coverage plans for all individuals:

Reimbursement for Telehealth, D-480.965
1. Our AMA will work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement for telehealth services, including telerehabilitation, to ensure increased access and use of these services by patients and physicians. Res. 122, A-19

VRC testimony was supportive of reaffirmation. The Reference Committee agrees, noting that rehabilitation services fall under the umbrella of healthcare services. We recommend the authors pursue a Medical Student Section Action Item (MSSAI) to send a letter to request that telerehabilitation be included in future advocacy efforts. The Reference Committee recommends reaffirmation of existing policy in lieu of this resolution.

(79) RESOLUTION 053 - REPURPOSING MEDICAL SURPLUS FOR HUMANITARIAN RELIEF AND MEDICAL EDUCATION

RECOMMENDATION:

Policy D-120.961 and H-135.939 be reaffirmed in lieu of Resolution 053.

RESOLVED, That our AMA encourage the development of systems that allow healthcare facilities to 1) reduce medical waste by tracking their preventable waste and 2) develop standardized protocols for medical surplus recovery for humanitarian relief and medical education.

VRC testimony was limited. Your Reference Committee supports the spirit of this resolution, but agrees with testimony from the House Coordination Committee (HCC) that this resolution is covered by existing policy. We recommend reaffirmation of existing policies D-120.961 and H-135.939 in lieu of this resolution.

D-120.961 Personal Medication and Medical Supplies in Times of Disaster

Our AMA urges continued dialogue with appropriate federal agencies, medical societies, health care organizations, and other appropriate stakeholders to: (a) ensure timely distribution of and access to medications for acute and chronic medical conditions in a disaster; (b) issue guidance to health professionals and the public on the appropriate stockpiling of medications for acute and chronic medical conditions in a disaster or other serious emergency; and (c) deliberate the design, feasibility, and utility of a universal mechanism, that provides the essential health and medical supplies and information that can assist emergency medical responders and other health care personnel with the provision of medical care and assistance in a disaster or other serious emergency.

H-135.939 Green Initiatives and the Health Care Community

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

(80) RESOLUTION 056 - REGULATION OF DATA FROM MOBILE HEALTH TECHNOLOGY

RECOMMENDATION:

Policy H-480.943 be <u>reaffirmed in lieu of</u> Resolution 056.

RESOLVED, that AMA policy H-315.983 Patient Privacy and Confidentiality be amended by addition and deletion as follows:

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 and mobile health technology companies 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, and mobile health technology companies to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies and mobile health technology companies 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.

VRC testimony was limited. The House Coordination Committee (HCC) included this resolution on their reaffirmation consent calendar. Your Reference Committee agrees with HCC that the resolution is covered under existing AMA policy, specifically H-480.943 which discusses the privacy of mobile health applications.

H-480.943 Integration of Mobile Health Applications and Devices into Practice
1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.
2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.
4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.
5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.
6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks
7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.

8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.

(81) RESOLUTION 057 - SUPPORTING THE RESEARCH AND DEVELOPMENT OF THE “PERFECT POTATO”

RECOMMENDATION:

Policy H-480.958 be <u>reaffirmed in lieu of</u> Resolution 057.

RESOLVED, That our AMA supports agricultural and genetic research that aims to improve upon potatoes with factors such as increased heat-tolerance and micronutrient diversity.

VRC testimony was opposed to this resolution due to its narrow scope and an overlap with existing policy. The House Coordination Committee (HCC) recommends reaffirmation of Policy H-480.958 in lieu of this resolution. Your Reference Committee agrees with HCC’s recommendation of reaffirmation.

RECOMMENDED FOR FILING

(82) LGBTQ+ REPORT A – A REPORT ON THE STATUS OF REQUESTS RELATING TO LGBTQ+ AFFAIRS MADE BY THE AMA-MSS TO THE AMA

RECOMMENDATION:

LGBTQ+ Report A be filed.

Your Standing Committee on LGBTQ+ Affairs recommends this informational report be filed for use by the Medical Student Section.

The Reference Committee thanks the authors for a well-written informational report containing substantial evidence. VRC testimony, while limited, was supportive. This report can be used by MSS members to reference a history of LGBTQ+ policies and continued gaps in advocacy. Your Reference Committee recommends LGBTQ+ Report A be filed.